**NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT**

**I understand that, under the Health Insurance Portability & Accountability Act of 1996 (“HIPAA”), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:**

- **Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in my treatment directly or indirectly.**
- **Obtain payment from third-party payers**
- **Conduct normal healthcare operations such as quality assessments and physicians certifications.**

**Any other uses of my protected health information will require my written release.**

**I acknowledge by my signature below I have read and reviewed the complete Notice of Privacy Practices for Burcham Eyecare Center.**
**I wish to receive a copy of the Notice of Privacy Practices _____yes_____no**

**To help us serve you better please review and check the appropriate boxes.**
**Family Members:**
**______I give Dr. Burcham, Dr. Laurie, or Dr. Kent permission to speak to a family member about my treatment or care.**
**____I do not give Dr. Burcham, Dr. Laurie, or Dr. Kent permission to speak to another family member without my written consent.**

**Home telephone: Please check the appropriate boxes.**
**_____ Leave message with call back number only.**
**_____OK to leave detailed message on my home voicemail.**
**_____OK to leave information with another family member who answers phone when I’m not available.**

**Work telephone: Please check the appropriate boxes.**
**_____Leave message with call back number only.**
**_____OK to leave detailed message on my voice mail at work.**

**Patient Name(Print)___________________________________________**
**Relationship to Patient:________________________________________**
**(self, mother, father, etc.)**

**Signature:__________________________________________________**

**Date:_______________________________________________________**

Office use only:

**Unable to obtain patient signature for the following reason______________________**
**______________________________Date: __________Initials____________________**