NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

Mitchell Eye Institute, P.C.
8218 Wisconsin Ave, Suite P-10
Bethesda, Maryland 20814

Mitchell Eye Institute, P.C.
130 Park Street SE, Suite 300
Vienna, Virginia 20814

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 that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization had the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

PATIENT NAME: (PRINT) _____

PATIENT SIGNATURE: _____

Date: _____

GUARDIAN NAME/SIGNATURE: _____

Relationship to Patient: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment of the Notice of Privacy Practices, but was unable to do so as documented below:

Date: _____ Initials: _____ Reason: _____