Name:
Chart:
Date:

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability and 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 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 understand that I have access to your *Notice of Privacy Practices,* which contains a more complete description of the uses and disclosures of my health information. I understand that *Northern Virginia Ophthalmology Associates* ("NVOA") has the right to change its *Notice of Privacy Practices* from time to time and that I may contact them at any time 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, and health care operations. I also understand that NVOA is not required to agree to my requested restrictions, but if agreed upon, then NVOA is bound to abide by such restrictions.

Name of patient	Patient/guardian signature	Date

AUTHORIZATION FORM
FOR OTHER USES OF PROTECTED HEALTH INFORMATION

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you pursuant to the above Acknowledgement Form. The patient may desire other individuals such as family members to have access to their PHI. Use the spaces below to specify those individuals, their relationship to you, and any limitations (if any) on the extent of their access to your PHI (e.g. billing issues only), and any expiration date to that access. **Please list parent(s) name(s) if patient is a minor.**

Name	Relationship	Limitations/Expiration Date

The above mentioned protected health information may be subject to re-disclosure by the party receiving the information and may no longer be protected by the privacy rules. By signing this form, you authorize the Practice to use and disclose protected health information about you for the reasons mentioned above. You have the right to revoke this authorization at any time, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior authorization. Submit your revocation to the Privacy Officer of the Practice.

Name of patient	Patient/guardian signature	Date