**Ice Ophthalmology LLC**
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# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand that, under the *Health Insurance Portability & Accountability Act of 1996 (HIPPA)* 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 has 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 Private 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 healthcare 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

_____

Relationship to Patient

_____

Signature

_____

Date

_____

FOR OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on the Notice of Privacy
Practices Acknowledgement, but was unable to do so as documented below.

DATE _____
INITIALS_____REASON_____