

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

MORRO BAY OPTOMETRY

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's certifications.

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it. I consent to the use and disclosure of my protected health information for the above purposes.

Patient Name _____ Birth date _____

Signature _____ Date _____

Morro Bay Optometry is hereby authorized to release any information regarding my medical care to persons listed below: **(Please PRINT names clearly)**

Name	Phone Number
_____	_____
_____	_____
_____	_____

This authorization shall remain in effect until notified by patient in writing

OFFICE USE ONLY

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

DATE	INITIALS	REASON
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