

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Dr. Lawrence Cusma
Optometry
9 Gleason Road
Scotia, NY 12302

I understand that, under the Health Insurance Portability & Accountability Act of 1998 (“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 or indirectly.*
- *Obtain payments from third-party payers*
- *Conduct normal healthcare operations such as quality assessments and physician certifications.*

I have received, read and understood 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 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.

Print Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

I authorize this office to share or disclose my private information (medical &/or financial) with the following person(s):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

FOR OFFICE USE ONLY

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

Date:	Initials:	Reason:
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