ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for the future care or treatment. I understand that this information serves as:
1) A basis for planning my care and treatment. 2) A means of communication among the health professionals who contribute to my care. 3) A source of information for applying my diagnosis and surgical information to my bill. 4) A means by which a third party payer can verify that services billed were actually provided. 5) And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I have the right to restrict certain disclosures of protected health information to a health plan if I pay out of pocket in full for services rendered. I understand that I will be notified of any breach of unsecured protected health information. I understand I have the right to request an electronic copy of my electronic health record and a copy of this acknowledgement.

I acknowledge this office has a **Notice of Privacy Practices** that gives a more complete description of information uses and disclosures as well as a description of my privacy rights. I understand that I can review the notice prior to signing this acknowledgement. I understand that the organization reserves the right to change their notice and practices and will provide me a copy of any revised notice.

I authorize Pastore-Tran Eyecare, Inc. to release my protected health information by □ text □ message left on any phone number provided □ email AND/OR to the following individuals (relationship)_____
_____

Patient signature or Legal representative_____ Date_____

For Office Use Only

I have made a good faith effort to obtain a written acknowledgment of receipt of the Notice of Privacy Practices for Pastore-Tran Eyecare, Inc. dba Active Florida Eyecare but was unable to for the following reason: □ Patient refused to sign □ Patient is unable to sign □ Other_____
_____Witness signature_____ Date_____