Acknowledgment of Receipt of Notice of Privacy Practices

VisionCare Optometry of Elk Grove
9717 Elk Grove Florin Rd. Ste B
Elk Grove, Ca 95624
916-685-3369

Patient Name:____

Patient D.O.B:__________________ Patient Phone Number:__________________________

Patient Address:____

Signing this document signifies that you understand the HIPPA law and how it protects your medical and personal information. If you would like a detailed copy of the law, please advise the staff and we will be glad to give you a copy.

In the course of providing services to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct healthcare operations involving our office. The Notice of Privacy Practices describes these uses and disclosures in detail.

I acknowledge that I understand the Notice of Privacy Practices from Dr. Thuy T. Ha, O.D.

____ ____________________
Signature Date

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form:

________________________________ ____________________________________
Relationship to patient Print Name