Notices of Privacy Practices Acknowledgement

Pediatric Eye Associates of Northern New Jersey
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HIPAA Compliance Patient Consent Form

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my health information. I acknowledge that I have received 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 above address to obtain a current copy of the Notice of Privacy Practices.

If the terms of the notice changes, I am aware I will be notified at my next visit to update my signature/date. I understand that I may request in writing that you restrict how my private information is used and disclosed for treatment, payment, or healthcare operations. I, also, understand you are not required to agree to my requested restriction, but if you do agree, then you are bound to abide by such restrictions.

In signing this form, 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.

In signing this form, I understand that:

_____ protected health information may be disclosed or used for that treatment, payment, or healthcare operations.
_____ the practice reserves the right to change the privacy policy as allowed by law.
_____ the practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
_____ the patient has the right to revoke this consent in writing at any time and all disclosures will then cease.
_____ the practice may condition receipt of treatment upon execution of this consent.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____

Official 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: