Great River Eye Clinic
formerly Crosby Eye Clinic

1-800-952-3766

Ophthalmology
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Baxter, Minnesota 56425
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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Patient Name: _____

DOB: _____

I understand that under the Health Insurance Portability and 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 certifications.

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 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 agree then you are bound to abide by such restrictions.

Signature _____ Date _____

Relationship to Patient _____ Date _____

You Can Choose An Authorized Representative(s)

You can give a trusted person permission to talk about your health information with us, see your information and act for you on matters related to your healthcare. This person is called an "authorized representative." If you ever need to change your authorized representative, you must sign another form with our office.

Name _____ Relationship _____

Name _____ Relationship _____

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 _____