



**ADVANCED
VISION CARE**

Notice of Privacy Practices Acknowledgment Form / HIPAA

Our Notice of Privacy Practices provides information about how we may use and release protected health information about you. You have the right to review our Notice before signing this form. As provided in our Notice, the terms of our Notice are subject to change. If we change our Notice, you may obtain a revised copy by writing our practice or requesting a copy from our front desk staff.

You have the right to request that we restrict how protected health information about you is used or released for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and release of protected health information about you for treatment, payment or healthcare operations as described in our Notice. You have the right to revoke this consent, in writing, except if we have already made releases in reliance on your prior consent.

Patient Signature _____

Please Print _____

Date _____