NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGMENT OF RECEIPT

Our **Notice of Privacy Practices** provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this acknowledgment of receipt. By signing this form, you are making the following statements:

- I have received a copy of Michiana Eye Center's Notice of Privacy Practices with an effective date of September 23, 2013.
- By accepting treatment, I understand that my protected health information may be disclosed or used by Michiana Eye Center for treatment, payment, healthcare operations and other permitted uses.
- I understand that I have the right to access, amend and/or restrict the use of my information, however Michiana Eye Center does *not* have to agree to those restrictions.
- I understand that Michiana Eye Center has the right to change the Notice of Privacy Practices.

Patient's Printed Name:_____

Patient Representative's Printed Name:_____

Patient or Representative's Signature:_____Date_____

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