Oliver Opticians
Anthony B. Kouchak, O.D.
5776 Dow Avenue
Alexandria, VA 22304

Notice of Privacy Practices Acknowledgment

Name:	DOB:	Date:

I understand that, under the Health Insurance Portability and Accountability Act of 1996 ("HIPPAA"), 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
- Any other lawful reason.

I have had the opportunity to understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization at any time at the address below 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 healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Signature:	Relationship to Patient:

Office Only: I attempted to obtain the patient's signature in acknowledgment on this Notice of Privacy Practices Acknowledgement, but was unable to do so because:

_____

Date:	Office Signature: