New Jersey Vision Associates, P.C.

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HIPAA ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. These rights are more fully described in New Jersey Vision Associates' Notice of Privacy Practices, updated effective January 1, 2020.

New Jersey Vision Associates is permitted to review the Notice of Privacy Practices at any time. We will provide you with a copy of the revised Notice of Privacy Practices upon your request.

I ____ **(patient's name)** understand that as part of my healthcare, this office originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I acknowledge that I have been provided with and understand that this office's Notice of Privacy Practices provides a complete description of the uses and disclosures of my health information. I understand that:

- I have the right to review this office's Notice of Privacy Practices and prior to signing this acknowledgment;
- This office reserves the right to change their Notice of Privacy Practices and prior to implementation of this will mail a copy of any revised notice to the address I've provided if requested.

Signature of Individual or Legal Representative ____

Printed Name of Individual or Legal Representative ____________________________________

If Signed by Patient Representative, State Relationship __________________________________

Date ____

FOR OFFICE USE ONLY

I,________________________________ **(employee name)** attempted to obtain the patient's acknowledgment of receipt of Notice of Privacy Practices, but was unable to do do.
Reason acknowledgment and consent not obtained: __________________________________

Employee Signature____________________________________ Date______________________