COMPLETE EYE CARE
1012 1st Ave N
Great Falls, MT 59401

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act (HIPAA), I have certain rights concerning the privacy of my health information. I understand that this information can and will be used to:

1. Plan, conduct, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in my treatment directly and indirectly.
2. Obtain payment from insurance companies or third-party payors.
3. Conduct normal healthcare operations such as quality assessment and physician certifications.

I understand that a copy of this healthcare facility's **Notice of Privacy Practices** containing a more complete description of the uses and disclosures of my health information is available upon request. 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 Complete Eye Care and its affiliates restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operation. I also understand that this healthcare facility is not obligated to agree to requested restrictions. If this healthcare facility does agree to requested restrictions, then we are bound to abide by such restrictions as stated in writing and signed by myself and a representative of Complete Eye Care.

Patient Name: _____

Parent/Guardian (if patient is a minor): _____

Signature: _____ Date: _____