NORTHERN WATERS OPHTHALMOLOGY SC
2111 BEASER AVENUE
ASHLAND WI 54806

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), 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

I have been offered your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. 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 above address 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 health care 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: _____

Date: _____

Patient Name: _____
PLEASE PRINT

Relationship to pt: _____

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As the above signed, I authorize the following person(s) to request and receive information regarding my health records and/or account at Northern Waters Ophthalmology, S.C. :

_____ Relationship:_____

_____ Relationship:_____

_____ Relationship:_____

PLEASE USE THE REVERSE SIDE FOR ADDITIONAL PERSONS OR COMMENTS.

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on the Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date Initials Reason: