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# Patient Acknowledgment of Receipt of Privacy Practices Notice

I,_____, hereby acknowledge that I have reviewed and received a copy of this office's Notice of Privacy Practices explaining:

- How this office will use and disclose my protected health information.
- My privacy rights in regard to my protected health information.
- This office's obligation concerning the use and disclosure of my protected health information.

I understand that the Notice of Privacy Practices may be revised from time to time and that I am entitled to receive a copy of any revised Notice of Privacy Practices upon request.

I also understand that if I have any questions or complaints, I may contact:

Comprehensive EyeCare Partners
50 S. Stephanie Street, Suite 101
Henderson, NV 89012

ATTN: Compliance Officer
Telephone: 702-463-7653

You may also contact the Secretary of the U.S. Department of Health and Human Services with any concerns regarding our privacy and security policies and procedures. Please contact our office for information on how to contact the U.S. Department of Health and Human Services.

Patient or Personal Representative

Signature_____ Date_____/_____/_____

**For Office Use Only**:

We made a good faith effort to obtain an acknowledgment of_____receipt of our Notice of Privacy Practices. In spite of these efforts, our office has been unable to obtain a signed acknowledgment of receipt for the following reasons:

- ☐ Patient refused to sign (date of refusal)_____/____/_____
- ☐ Communication barriers prevented obtaining acknowledgment.
- ☐ An emergency situation prevented us from obtaining acknowledgment.
- ☐ Other_____.

Attempt was made by: _____ Date_____/_____/_____