TRI-COUNTY VISION ASSOCIATES, LLC (860) 423-2565
16 Walnut St. Willimantic, CT 06226 fax (860) 423-8058

NOTICE OF PRIVACY PRACTICES 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:

- Provide, coordinate, or manage my healthcare and any related services with a third party such as a health agency or another physician involved in my care.
- Obtain payment from third-party payers such as insurance & worker’s compensation companies.
- Perform daily office healthcare operations such as but not limited to quality assessments, employee review activities, physician certifications, and conducting other business activities. For example, we may call you by name in the waiting room when your doctor is ready to see you.

I have been informed of and given the right to review and received a copy of *Tri-County Vision’s 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 the *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 Private Practices*.

I understand that I may request in writing that Tri-County Vision restricts how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that Tri-County Vision is not required to agree to my requested restrictions, but if agreed then they are bound to abide by such restrictions.

I would also like the following communication preferences.

Tri-County Vision may phone, email, or send a text reminding me & confirming appointments? YES NO

Tri-County Vision may leave a message on my answering machine at home or on my cell phone? YES NO

Tri-County Vision may discuss medical or financial information with a member(s) of my family? YES NO

If YES, please provide the name(s) of family members allowed: ____

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Patient Name: (PRINT) ____

Relationship to Patient: (CIRCLE ONE) SELF PARENT/GUARDIAN OTHER:______________________________

Signature: ____ **Date:** ______________________________

OFFICE USE ONLY

I attempted to obtain the patients signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

Date:	Initials:	Reason: