ARMESTO
EYE ASSOCIATES
LLC

HIPAA NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

Regulations require that we make a "good faith" effort to provide you with a copy of our HIPAA Privacy Practices Notice. However, you are not required to accept the Notice, only to acknowledge that we have made you aware of our HIPAA Notice of Privacy Practices.

I, _____, have received a copy of,
[Patient Name]
or acknowledge the existence of Armesto Eye Associates' HIPAA Notice of Privacy Practices.

_____ _____
Patient Signature Date

I give my permission to release my medical information to:

_____ _____
Name Relationship

_____ _____
Name Relationship

FOR OFFICE USE ONLY

WHEN EFFORTS TO OBTAIN PATIENT ACKNOWLEDGEMENT WERE UNSUCCESSFUL:

NAME OF PATIENT: _____

I provided the above-named patient with the HIPAA Notice of Privacy Practices for Armesto Eye Associates on _____.
Date

Describe how Notice was offered or provided:

[ ] Offered copy and patient refused to accept delivery.
[ ] Offered copy and patient accepted delivery but refused to sign.
[ ] Other [describe]:

_____

_____ _____
Employee Signature Date

REV. 01/18/13