



*"Commitment to Excellence – Spirit of Service"*

**HIPPA NOTICE OF PRIVACY PRACTICES**

THIS NOTICE DESCRIBES HOW MEDICAL/PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

**Summary:**

By law, we are required to provide you with our Notice of Privacy Practices (NPP). This notice describes how your medical information may be used and disclosed by us. As a patient, you have the following rights:

1. The right to inspect and copy your information.
2. The right to request corrections to your information.
3. The right to request that your information be restricted.
4. The right to request confidential communications.
5. The right to a report of disclosures of your information.
6. The right to a paper copy of this notice.
7. The right to file a complaint if you feel your privacy has been violated.

We want to assure you that your medical/protected health information is secure with us. This Notice contains information about how we will insure that your information remains private.

**Acknowledgement of Notice of Privacy Practices**

I hereby acknowledge that I have received a copy of the West Georgia Eye Care Center's **NOTICE OF PRIVACY PRACTICES**. I understand that if I have questions or complaints regarding my privacy rights, that I may contact the person named as the Privacy Officer.

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Patient or Representative Name (Please Print)

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Patient or Representative Signature

Date

- Patient refused to sign
- Patient was unable to sign because \_\_\_\_\_

Documented by: \_\_\_\_\_