

**James River Eye Physicians, P.C.**

**PATIENT ACKNOWLEDGEMENT FORM**

By signing this form, you acknowledge you have had the opportunity to review the *Notice of Privacy Practices* of James River Eye Physicians, P.C. in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.

Acknowledgement signature \_\_\_\_\_

Printed name – Patient or Representative \_\_\_\_\_

Relationship to Patient (if other than patient) \_\_\_\_\_

Date: \_\_\_\_\_

In front of \_\_\_\_\_  
Printed name of Practice representative