BATON ROUGE EYE PHYSICIANS

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

BATON ROUGE EYE PHYSICIANS HAS PROVIDED ME WITH A NOTICE OF PRIVACY PRACTICES. THIS DOCUMENT EXPLAINS MY RIGHTS AS A PATIENT AND WHERE AND TO WHOM MY HEATH INFORMATION MAY BE RELEASED.

I UNDERSTAND BATON ROUGE EYE PHYSICIANS HAS THE RIGHT TO CHANGE ITS NOTICE OF PRIVACY PRACTICES FROM TIME TO TIME AND THAT I MAY CONTACT THIS ORGANIZATION AT ANY TIME TO OBTAIN A CURRENT COPY.

I UNDERSTAND THAT I MAY REQUEST IN WRITING THAT YOU RESTRICT HOW MY PRIVATE INFORMATION IS USED OR DISCLOSED TO CARRY OUT TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS. I ALSO UNDERSTAND YOU ARE NOT REQUIRED TO AGREE TO MY REQUESTED RESTRICTIONS, BUT IF YOU DO AGREE THEN YOU ARE BOUND TO ABIDE BY SUCH RESTRICTIONS.

PATIENT SIGNATURE_____

DATE_____

OFFICE USE ONLY

I ATTEMPTED TO OBTAIN THE PATIENT'S SIGNATURE IN ACKNOWLEDGEMENT ON THIS NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT, BUT WAS UNABLE TO DO SO AS DOCUMENTED BELOW:

DATE: INITIALS REASON