NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certification.

I have received, read and understand Katie Kimble Wonch, O.D., LLC & Infinite Vision, LLC *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that Katie Kimble Wonch, O.D., LLC & Infinite Vision, LLC has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at anytime at the address below to obtain a current copy of the *Notice of Privacy Practices.*

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 Name:(Print)_____Relationship to Patient: _____

Signature: _____Date:_____