Chino Hills Eyecare
Optometry

Dr. Suneet K. Gupta, O.D.

NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGEMENT OF RECIEPT AND GENERAL CONSENT

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 for purposes of treatment, payment, and conduct normal healthcare operations and as authorized or required by law under the circumstances described in the Notice of Privacy Practices.

I have received, read and understand your Notice of Privacy Practices, which contains a more detailed description of the uses and disclosures of my health information. I also understand that the practice has the right to change its Notice of Privacy Practices from time to time and I can always obtain a current copy. I further consent to the release of my health information.

Patient name:_____

Signature:_____ Date:_____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient:_____

Print Name:_____

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:_____Intials:_____Reason:_____

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