Notice of Privacy Practices Acknowledgment

Legacy Eye Care, LLC

Patient Acknowledgment form

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent. As provided in our notice the terms of our notice may change. If we change our notice, you may obtain a revised copy by contacting the **Privacy Officer at 804-451-4791.**

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or healthcare operations. You are not required to agree to this restriction but if you do, you are bound by our agreement.

By signing this form, you consent to use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent in writing, except where we have already made disclosures in reliance on your prior consent.

Patient's Name (Print):____Date_______________

Patient's Signature:____Date_________________