

HIPAA Privacy Notice and Acknowledgment

Eyes on Burbank Optometry

2005 W. Alameda Ave., Burbank, CA 91506

Phone: 818-476-4606

Notice of Privacy Practices

Eyes on Burbank Optometry is committed to protecting the privacy of our patients' medical information. This notice describes how your medical information may be used and disclosed, as well as how you can access this information.

1. Uses and Disclosures of Health Information

We may use or disclose your health information for:

- **Treatment:** To provide and coordinate your healthcare, such as sharing information with other healthcare providers involved in your care.
- **Payment:** To bill and collect payment for services provided, such as submitting claims to insurance companies.
- **Healthcare Operations:** For operational purposes, such as quality assessment and training activities.

Other uses and disclosures will be made only with your written authorization, which you may revoke at any time, except to the extent that action has already been taken.

2. Your Rights Regarding Health Information

You have the following rights:

- **Right to Inspect and Copy:** You may view and obtain copies of your health information.
- **Right to Amend:** If you feel the information we have is incorrect, you may request an amendment.
- **Right to an Accounting of Disclosures:** You may request a list of certain disclosures we have made.
- **Right to Request Restrictions:** You may request limitations on certain uses and disclosures, although we are not required to agree to the restrictions.
- **Right to Receive Confidential Communications:** You may request that we communicate with you in a specific way.

3. Changes to This Notice

Eyes on Burbank Optometry reserves the right to change this notice at any time. The revised notice will be effective for information we already have about you as well as any information we receive in the future. The current notice will be available at our office and on our website.

Acknowledgment of Receipt of Notice of Privacy Practices

By signing below, I acknowledge that I have received a copy of *Eyes on Burbank Optometry's* Notice of Privacy Practices.

Patient Name: _____

Date of Birth: _____

Signature of Patient or Legal Guardian: _____

Date: _____

Thank you for your cooperation in helping us maintain compliance with HIPAA regulations and for choosing *Eyes on Burbank Optometry* for your eye care needs.