BROWN
EYE CARE ASSOCIATES
Ophthalmology and Ophthalmic Surgery

751 Teaneck Road
Teaneck, NJ 07666
201-833-0006

Robert H. Brown, M.D
R. Stephen Brown, M.D.
Christopher D. Brown, M.D.
Andrew C. Brown, M.D.

Notice of Privacy Practices Acknowledgement

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Brown Eye Associates complies with the Health Insurance Portability and Accountability Act of 1996 and Department of Health and Human Services rules that are designed to preserve the privacy of identifiable information.

By signing below, I acknowledge that I am aware that this office has a HIPPA policy in effect and I understand that a copy of the policy will be made available to me at my request. I consent to the use and disclosure of my health information to treat me and arrange for my medical care, to seek and receive payment for services provided to me, and for the business operations of this office by its staff.

Patient Name _____

Signature _____

Relationship to Patient _____

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**