ACKNOWLEDGEMENT
OF
PRIVACY PRACTICES

Dieter Steimann, O.D.
Hans Steimann, O. D.
18282 Imperial Hwy.
Yorba Linda, CA 92886
(714) 777-3969

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

- Provide and coordinate my treatment among a number of health care provider who may be involved in that treatment directly and indirectly
- Obtain payment from the third-party payers for health care services
- Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my eye care provider's ***Notice of Privacy Practices*** containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such ***Notice of Privacy Practices***. I understand that my eye care provider has the right to change the ***Notice of Privacy Practices*** and that I may contact this office at the address above 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 and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restriction.

Patient Name (Print):_____

Signature:_____

Date:_____

Dependent family members also covered by this acknowledgement:

_____

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