Marc H. Sherman, O.D., F.C.O.V.D.
Steven J. Zorn, O.D., F.A.A.O

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 (“HIPPA”) I have certain rights to privacy regarding my protected health information (PHI). I understand that this can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read, and understood Dr. Marc Sherman and Dr. Steven Zorn’s Notice of Privacy Practices containing a more complete description of the uses and disclosures of my PHI. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of this Notice.

Patient Name or Legal Guardian Name: ____________________________________

Signature: ____

Date: ____________________________

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For Office Use Only

Unable to obtain Patient’s signature reason documented below.

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Date **Initial** **Reason**