



## Purpose of this Acknowledgement

By signing below, I acknowledge that I have received the provider's Notice of Privacy Practices, which describes how my protected health information may be used and disclosed and explains my rights regarding my health information and how I may exercise those rights.

## Acknowledgements and Statements

1. I acknowledge that I have been provided with, and have had the opportunity to review, the Notice of Privacy Practices.
2. I understand that the Notice of Privacy Practices may be updated or revised, and that I may obtain the current version at any time upon request or by accessing [eyesofnorthdakota.com](http://eyesofnorthdakota.com).
3. I understand that I may:
  - (a) request restrictions on certain uses and disclosures of my protected health information,
  - (b) request confidential communications,
  - (c) inspect and obtain a copy of my health information,
  - (d) request amendments to my health information, and
  - (e) receive an accounting of disclosures, as described in the Notice of Privacy Practices.
4. I understand that the provider is not required to agree to all requested restrictions, but will comply with any restriction that the provider agrees to and any restriction that is otherwise required by applicable law.
5. I understand that I may file a complaint if I believe my privacy rights have been violated, without fear of retaliation, using the process described in the Notice of Privacy Practices.

## Patient Information and Signature

Patient Name: \_\_\_\_\_

Signature of Patient or Personal Representative: \_\_\_\_\_

Date: \_\_\_\_\_

If signed by a Personal Representative, state authority (e.g., parent, legal guardian, health care proxy): \_\_\_\_\_