



KIRMAN EYE

HIPAA Compliance Confirmation of Receipt

I acknowledge that I received a copy of the Kirman Eye Privacy Policy in accordance with the **Health Insurance Portability and Accountability Act (HIPAA)**. Private information will be used in accordance with office policy unless a written request is made to modify these procedures either by or on behalf of the patient.

Date _____

Patient's Name _____

Authorized Signature _____