WILLIAM E. CONN, O.D.
782 OLD HICKORY BLVD SUITE 204
BRENTWOOD, TN 37027
Contact Person: Office Manager

ACKNOWLEDGEMENT OF PRIVACY POLICY AND PRACTICES

I understand that in an attempt to protect the privacy of my identifiable health information, Dr. William E. Conn has established a ***Privacy Policy*** and guidelines for ***Privacy Practices*** within his office. This information details the use and/or disclosure of information contained in my personal medical/optometric records kept for the purposes of diagnosis, treatment, payment and health care operations. In accordance with HIPAA regulations, Dr. William Conn's ***Notice of Privacy Practices*** has been made available to me while in the office today. Should I choose to have a personal copy, one will be given to me at no charge.

[ ] I ***HAVE READ***, understand and acknowledge the ***Notice of Privacy Practices*** of Dr. William E. Conn.

[ ] I have ***ELECTED NOT TO READ*** the ***Notice of Privacy Practices*** of Dr. William E. Conn.

[ ] A copy of Dr. William E. Conn's ***Notice of Privacy Practices*** was given to me today.

Signature____Date_____________________