



DAVID A. EWING-CHOW, MD, PLLC  
TREATMENT AND SURGERY OF THE EYE

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THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.  
**PLEASE REVIEW THIS NOTICE CAREFULLY**

**ACKNOWLEDGEMENT AND SUMMARY  
OF NOTICE OF PRIVACY PRACTICES**

**We, at David A. Ewing-Chow, MD, PLLC pledge to give you the highest quality health care and to have a relationship with you that is built on trust. This trust includes our commitment to respect the privacy and confidentiality of your health information.**

This Notice is being given to you because federal law gives you the right to be told ahead of time about:

- How David A. Ewing-Chow, MD, PLLC will handle your medical information
- David A. Ewing-Chow, MD, PLLC’s legal duties related to your medical information
- Your rights with regard to your medical information.

When you need care our practice gathers information about you to provide that care and uses this information within the health system and shares the information outside the system to continue to provide you excellent care. David A. Ewing-Chow, MD, PLLC, is obligated to protect your information in a manner consistent with the laws designed to uphold the privacy and confidentiality of your health information. You have certain rights regarding your information that is contained in David A. Ewing-Chow, MD, PLLC’s records, such as the right to request restrictions on the uses of your information and the right to request access to and a copy of your health information. This brief notice is a summary only. A comprehensive notice is attached to a clipboard for your review and available on our website. At your request a copy can be made available.

I acknowledge that I have been given access to a copy of DAVID A. EWING-CHOW, MD, PLLC’s Notice of Privacy Practices.

Print Name	Patient’s Signature	Date
Print Name	Patient’s Authorized Representative (If Applicable)	Date

***For DAVID A. EWING-CHOW, MD, PLLC, Use Only***

Good faith efforts were made to obtain the above-written acknowledgement as follows:

The reason(s) the patient’s/authorized representative’s acknowledgement was not obtained is as follows:

Documented By:

Print Name and Title	Signature	Date
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