

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES FOR ASSOCIATED EYE CARE FACILITY

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices. I also would like to give permission to the following person(s) to be able to have access to my personal health information:

Name of person(s)/Relationship to you

Print your name

Your signature

Date

For Office Use Only

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this patient but it could not be obtained because:

The Patient refused to sign

Due to an emergency situation it was not possible to obtain a signature.

We were not able to communicate with the Patient.

Other.(please provide details)

Employee Signature

Date

This form does not constitute legal advice and covers only federal, not state, law.