

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: _____ Date of Birth: _____

I have been given a copy of Ophthalmic Associates *Notice of Privacy Practices* ("Notice"), which describes how my health information is used and shared. I understand that the Practice has the right to change this *Notice* at any time. I may obtain a current copy by contacting the Practice Privacy Officer.

My signature below acknowledges that I have been provided with a copy of the *Notice of Privacy Practices*:

Signature of Patient or Personal Representative

Date

Print Name

Personal Representative's Title (e.g., Guardian, Health Care Power of Attorney)

For Facility Use Only: Complete this section if you are unable to obtain a signature.

If the patient or personal representative is unable or unwilling to sign this *Acknowledgement*, or the *Acknowledgement* is not signed for any other reason, state the reason:

Completed by:

Signature of Practice Representative

Date

Print Name and Title

File Original in Patient's Health Care Record

