Acknowledge Of Privacy Practices

I, ______________________ acknowledge that I have received a copy of the Notice of Privacy Practices from Family Eye Center, OD, PA.

I have listed individuals that are authorized to receive my protected health information. I am aware that I can revoke the authorization for any individual at any time, but must do so in writing.

______________________________________ ______________

Signature of Patient Date

______________________________________ ______________

Signature of Patient Representative & Relationship Date
(Required if patient is a minor or an adult unable to sign form)

The following individuals have my authorization to access my Protected Health Information

Name	Relationship	Date of Birth
______________	______________	______________
______________	______________	______________
______________	______________	______________
______________	______________	______________