VISIONARY OPHTHALMOLOGY AND CATARACT CARE

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*You may refuse to sign this acknowledgment

I have been offered a copy of this office's Notice of Privacy Practices.

_____I give permission for messages to be left on my answering machine or voice mail. If no, please write the word NO here_____.

I give my permission for Visionary Ophthalmology and Cataract Care to speak to the following person/people on my behalf:

_____ _____

NAME RELATIONSHIP

_____ _____

NAME RELATIONSHIP

_____ _____

NAME RELATIONSHIP

SIGNATURE_____

Please Print Name _____

If signing for a minor, name of patient_____

Date_____

FOR OFFICE USE ONLY

Attempted to obtain written acknowledgement of receipt of Notice of Privacy Practices, but Acknowledgment could not be obtained because:

_____ Individual refused to sign

_____ Communication barriers prohibited obtaining the acknowledgment

_____ An emergency prevented obtaining acknowledgment

_____ Other: