ZULEIKA M. GHODSI, MD, PC
DELMARVA LASER EYE CENTER

I acknowledge that a copy of Zuleika M. Ghodsi, MD, PC dba. Delmarva Laser Eye Center "NOTICE OF PRIVACY PRACTICES" has been provided to me and is posted throughout the office for my review. I acknowledge that I am aware of the September 23rd "Final Ruling" regarding additions and changes in HIPAA requirements and the "NOTICE OF PRIVACY PRACTICES" and that Delmarva Laser Eye Center has answered all of my questions or concerns regarding these changes.

Patient Name:_____
(Print)

Signature:_____Date_____
(If Minor Parent or Legal Guardian must sign)

Please check the box below indicating if you would like a copy of the HIPAA/HITECH, "NOTICE OF PRIVACY PRACTICES" and the Omnibus "Final Rule" requirements effective 9/23/13.

_____**YES** _____**NO**