Notice of Privacy Practices – Acknowledgement of Receipt

I, ____ acknowledge that I have received and reviewed the written
(*patient name*)
Notice of Privacy Practices from Ophthalmology Associates, S.C.

Signed ____ Date ______________________
(*Patient or legal representative or parent if patient under age 18*)

Please indicate below how you would like Ophthalmology Associates, S.C. to leave messages disclosing your protected health information:

___ Home answering machine # ____________________________________

___Work phone # ____________________________________

___ Cell phone # ____________________________________

___ No message should be left, speak to me directly

The following are family members, legal representatives or a close friend I give permission to Ophthalmology Associates, S.C. to disclose my protected health information with:

_________________________	______________________	_______________________
(Individual's Name)	*(Relationship)*	*(phone)*
_________________________	______________________	_______________________
(Individual's Name)	*(Relationship)*	*(phone)*

For Office Use Only :

Acknowledgement was unable to be obtained, Reason: ____
____
____

____ ____
(*Employee Signature)* *(Date)*