ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By my signature below, I acknowledge that I have received Ophthalmology Associates Notice of Privacy Practices.

_____ Account# _____
Patient Signature

_____
Date

_____
Patient Declined to Sign / Employee / Date

Who may we give information to regarding your condition, treatment or diagnosis?

Name **Phone** **Relationship**

_____

_____

_____

_____

_____

Is there anyone who should <u>never</u> have this information:

_____

I can be contacted regarding appointment and medical information in the following methods:

☐ **Text Message to** _____

☐ **Email address** _____

☐ **Cell Phone** _____ **May we leave a message YES NO**

☐ **Home number** _____ **May we leave a message YES NO**

☐ **Work number** _____ **May we leave a message YES NO**