Last Name: _____

First Name: _____

Date of Birth: _____/_____/_____

SOUTHERN EYECARE ASSOCIATES

Acknowledgement of Receipt

I have been given a copy of Southern EyeCare Associates' Notice of Privacy Practices version effective June 8, 2015. I consent to the uses and disclosures of my health information as outlined in the Notice.

Privacy Options

☐ **I want NO ONE to receive my Personal Health Information except myself.**

☐ **I request the following person(s) BE ALLOWED to access my Personal Health Information:**

_____ _____

_____ _____

☐ **I request the following person(s) NOT BE ALLOWED to access my Personal Health Information:**

_____ _____

_____ _____

Communications

I give permission to leave a verbal message at my personal residence. ____Yes ____No

I give permission to leave a message regarding my appointment on my voicemail. ____Yes ____No

I give Southern EyeCare Assoc. permission to release any eye care notes to my personal physician ____Yes ____No

I give permission to call me at work. Work phone: _____ ____Yes ____No

Please Sign

Patient's Name (Print)	Patient's Signature	Date

If you are signing on behalf of the patient, please complete this section:

Representative's Name (print)	Representative's Signature	Date

Reason Patient Cannot SIgn

******Office Use Onlv******

If acknowledgement of receipt of the Notice of Privacy Practices is not obtained from the patient or the patient's representative, please explain your efforts to obtain acknowledgement and the reason you could not obtain it: