AFFILIATED EYE SURGEONS, LTD.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

In an attempt to protect your privacy regarding your medical history, the US Government has mandated that we notify you in writing of the recently passed privacy legislation. This acknowledgement page will be retained in patient's record.

Your signature below signifies that you have received our Notice of Privacy Practices for Protected Health Information.

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Signature of patient or legal guardian Date

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Printed name of patient

May we leave confidential messages on an answering machine?

YES ☐ If yes please indicate the phone number and sign below **NO** ☐

______________________ ______________________

Signature Phone Number

It is the practice of this office not to release your medical information to anyone without your written authorization. If you would like our office to discuss your confidential medical information with someone other than you (such as your primary care physician, spouse or family member) please list the person(s) and their relationship to you.

______________________ ______________________

Printed name of Authorized Person Relationship to Patient

______________________ ______________________

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______________________ ______________________

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