Acknowledgement of Receipt of Notice of Privacy Practices

Devine Eyes
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devineeyes@devineeyes.com

Patient Name: _____ DOB:_____

Signing this document signifies that you have received or decline a copy of our Notice of Privacy Practices.

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct healthcare operations involving our office. The Notice of Privacy Practices describes these uses and disclosures in detail.

I acknowledge that I have received/read the Notice of Privacy Practices from Devine Eyes.

Patients Signature: _____ Date: _____

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form:

Print Name: _____

Relationship: _____ Date: _____

Source of Authority: _____

☐ *Patient refused to sign*

Witness Name: _____ Date: _____

Witness Signature: _____

Updated 07/01/2014