ACKNOWLEDGEMENT
OF
NOTICE OF PRIVACY PRACTICES

The law requires that Carthage Eye Clinic, PA make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

☐ I have read or had explained to me Carthage Eye Clinic PA's Notice of Privacy Practice and agree to continue my care with Carthage Eye Clinic, PA under said terms.

☐ The Notice of Privacy Practice could not be read due to the emergent nature of the care of other reason described as

_____

_____

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

_____ _____
Patient Date

If you are signing as a personal representative of the patient, please indicate your relationship

_____ _____
Representative Relationship to Patient

Persons who we may discuss your information with:
Name_____DOB_____
Name_____DOB_____