Glacier Eye Clinic

ACKNOWLEDGMENT RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Clinic Notice of Privacy Practices. I understand that the Notice of Privacy Practices describes how Clinic may disclose and use my protected health information.

Patient Name: ____

Signature: ______________________________ **Date:** _______________

If signed by the Patient's personal representative, indicate:

A. Name of Signer: ____

B. Relationship to Patient: _______________________________________

If acknowledgment is not signed, indicate reason and efforts made to have acknowledgment signed.

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Original – Attach to Patient's Medical Record

Revised 06/2008