EYE DOCS OPTICAL

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT

Date:_______________

I acknowledge that I was provided with a copy of the EyeDocs Optical Notice of Privacy Practices.

_________________________ _________________________________

Print Patient Name | Signature of patient/guardian of minor

If completed by a patient's personal representative, please print and sign your name in the space below

_________________________ _________________________________

Print Personal Representative | Personal Representative's Signature

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Relationship

For EyeDocs Optical use only: Complete this section if this form is not signed and dated by the patient or patient's personal representative. I have made a good faith effort to obtain a written acknowledgement of receipt of EyeDocs Optical Notice of Privacy Practices but was unable to for the following reason: ☐ Patient refused to sign ☐ Patient unable to sign ☐ Other_____________ _____________________________ _____________________________ Employee Name Date
Place This In Patient Chart