ACKNOWLEDGMENT OF RECEIPT
OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided an opportunity to read/review a copy of the Notice of Privacy Practices for **Jamison Eye Care.**

Print Patient Name: _____

Date of Birth: _____

Signature of Patient: _____*

Date: _____

*If person signing is not the patient, please print your name and relationship to patient: _____

I (patient or representative) request a copy of the Notice of Privacy Practices:
Yes_____No _____

I authorize my protected health information to be given to:
Self only: _____
Spouse/Significant Other Name: _____
Answering Machine: Yes _____ No _____
Family Member(s): _____
Other: _____

Patient Signature: _____

FOR OFFICE USE:
If patient/representative requested copy of Notice, date copy was provided: _____

If no acknowledgment could be obtained, state the reasons why and the efforts taken to try to obtain the acknowledgment: _____
_____

TO CANCEL THIS AUTHORIZATION:
I hereby cancel my authorization to the release of the information outlines on this form.

Patient Signature: _____
Date: _____