ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

PATIENT NAME ____ DATE OF BIRTH _________________
(FIRST) (MIDDLE INITIAL) (LAST)

By signing below, I acknowledge that I have received Highland Retina Associates, LLC's Notice of Privacy Practices.

____ _____________________________
SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE

____ _____________________________
(PRINTED NAME IF LEGAL GUARDIAN) RELATIONSHIP TO PATIENT

Office Use:

This acknowledgement page should be retained in patient record. If acknowledgement could not be obtained from the patient, the reason(s) must be documented below:

_________ PATIENT DECLINED

_________ OTHER REASON (DESCRIBE BELOW):

____

____

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____ ____________________________
EMPLOYEE SIGNATURE DATE

____
EMPLOYEE PRINTED NAME

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