ASSOCIATED EYE SURGEONS

RECEIPT OF NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT FORM

I hereby acknowledge that on _____ , I received
(Date)
the Associated Eye Surgeons' Notice of Privacy Practices, which explains the ways in which my personal health information may be used or disclosed by Associated Eye Surgeons, and outlines my rights with respect to such information.

_____ _____
Patient's Signature or Authorized Representative Date

Please include a list of authorized family members, employer, friends, school officials, etc. that we may release your PHI to:

Person's Name	Relationship to Patient