OHIO
OPHTHALMOLOGY

Acknowledgement of Receipt of Notice of Privacy Practice

Patient Name: ____ Date: ______________________

Do we have permission to leave a message or voicemail on the phone numbers that you have provided?

Please circle: YES NO

Do we have permission to speak to anyone regarding your healthcare? If so, please list name(s), relationship(s), and phone number(s) below:

Name: _________________________________ Name: _______________________________

Relationship: ___________________________ Relationship: _________________________

Phone: ________________________________ Phone: ______________________________

By signing below I attest that I have been presented with a copy of the Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information. I also give permissions as stated above.

____ ______________________

Signature of Patient or Responsible Party Date

____ ______________________

Relationship to patient - if patient is not signing Date