Columbus Eye Clinic &
Laser Surgery Center

Acknowledgment of Receipt of Notice of Privacy Practices

By my signature below, I acknowledge that I have received Columbus Eye Clinic & Laser Surgery Centers' Notice of Privacy Practices.

Patient Name: _____Patient Date of Birth _____

Any physician, staff, employee or representative of Columbus Eye Clinic & Laser Surgery Center has my permission to **discuss** my account and medical conditions which may include symptoms, treatments, diagnosis, test results, medications or any other type of protected health information with the following persons in order to facilitate and coordinate my care, treatment and payment.

_____	_____	_____
Name	Relationship	Phone Number(s)
_____	_____	_____
Name	Relationship	Phone Number(s)
_____	_____	_____
Name	Relationship	Phone Number(s)

I understand that authorizing the release of my information to the above individual(s) is voluntary and does not affect my access to treatment. I can refuse to sign this form. I can revoke it by writing to Columbus Eye Clinic & Laser Surgery Center or completing a new form at any time. This authorization will remain in effect until I change or Revoke it. I understand that if information is shared with the above individuals it may be subject to re-disclosure by the individual(s).

Patient or Guardian's Signature _____ Date: _____

This acknowledgment page should be retained in patient's record. If acknowledgment could not be obtained from patient, the reasons must be documented below.

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment on this notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date: _____ Signature _____

Reason: _____

_____

_____