

Written Acknowledgement of Receipt of “Notice of Patient Privacy Practices”

I understand and have been provided with Larson Eye Center Ltd.’s “Notice of Privacy Practices” that provides information about how the practice may use and disclose medical information. I understand that I have the right to review the notice prior to signing this consent.

Larson Eye Center, Ltd. has the right to change the privacy practices that are described in the Notice of Privacy Practices at any time. A current “Notice of Privacy Practices” is posted in our patient waiting room with the current effective date. I may request and obtain the latest copy at any time.

Signature of Patient or Authorized Representative

Date

Printed name of Patient or Authorized Representative

Date

Relationship to Patient

_____ I authorize LEC to leave a message on my voicemail regarding test results or contact lenses.

Name of person(s) and relationship that you are authorizing LEC to disclose your protected health information to:

Name

Relationship

Contact Number

Name

Relationship

Contact Number

Name

Relationship

Contact Number