ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

I acknowledge that I have received a copy of The Eye and Laser Clinic Privacy Notice.

_____ _____

Patient or Personal Representative Signature Date

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient:

_____

****

I authorize the person(s) named below to have access to my financial/medical records at The Eye and Laser Clinic. This person(s) may access my financial/medical records with a written request, by phone or in person.

_____ _____

Name Relationship to Patient

_____ _____

Name Relationship to Patient

_____ _____

Patient or Personal Representative Signature Date

○ I am the ONLY person authorized to obtain my financial/medical records in any way.