CHADWICK BAY VISION CARE

Acknowledgement of Receipt of Notice of Privacy Practices

I, ____________________(name of patient), date of birth____________________Social Security no.____________________, acknowledge and agree that I have received a copy of the Chadwick Bay Vision Care's Notice of Privacy Practices.

______________________________________ ____________________________

Signature of Patient or Personal Representative   Date

______________________________________ ____________________________

Print Name of Personal Representative (if applicable)   Relationship of Personal Representative to patient

If this acknowledgement is signed by someone who is not the patient listed at the top of this form, provide a description of the signer's authority to act for the patient.

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I authorize Chadwick Bay Vision to release information regarding my "Health Information" to ______________________________. This authorization is in effect until revoked by me in writing.

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FOR OFFICE USE ONLY:

Chadwick Bay Vision Care made the following good faith efforts to obtain the above-referenced individual's written acknowledgement of receipt of the Notice of Privacy Information practices:

( )Patient/personal representative was offered copy and individual refused to accept delivery.
( )Patient/personal representative accepted delivery of copy but refused to sign form to acknowledge Receipt of Notice.
( )Other:____

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Staff members Signature and date

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Print Name