HIPAA PRIVACY
ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I, _____ [Please print full name], have been presented with the Notice of Privacy Policy of CDR EYE ASSOCIATES, and have been offered a copy of such policy to keep for my records.

_____ [Please initial here] I hereby acknowledge that I have been provided with a copy of the Policy.

_____ [Please initial here] I hereby refuse to acknowledge receipt of the Policy. I understand that even though I may refuse to sign this acknowledgment, Provider may still provide treatment to me.

_____

Signature of Patient Date

I, _____ , attempted to obtain the written acknowledgment of receipt of the Policy of Provider on _____ , but acknowledgment could not be obtained because:

_____ [Please initial here] Patient refused to sign.

_____ [Please initial here] Patient could not be communicated with sufficient to obtain acknowledgment.

_____ [Please initial here] Emergency circumstances prevented securing acknowledgment.

_____ [Please initial here] Other (Please specify) _____

_____

_____

_____

Signature of Provider Representative Date