ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

Family Eyecare of Glendale
19420 N. 59th Ave.
Ste E-525
Glendale, Az 85308
(602) 843-2900

Patient Name: ____

Signing this document signifies that you have received a copy of our Notice of Privacy Practices.

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services and/or to conduct healthare operations involving our office. The Notice of Privacy Practices you have been given describes these uses and disclosures in detail.

I acknowledge that I have received the Notice of Privacy Practices from Family Eyecare of Glendale.

Signature_______________________________________Date_______________

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign the form:

Relationship_________________________Print Name: _____________________

Source of Authority: ____