Patient Acknowledgement Form

Please Read and Sign Below

Natural Eyes of Weston's "notice of Privacy Practices" provides information on how we may disclose protected and private health insurance information about you. Please acknowledge receiving this document or that you have read this office's "Notice of Privacy Practices by initializing below:

_____
Patient's Initials

Our "Notice of Privacy Practices" states that we reserve the right to change the terms described. Should this happen, you will receive a copy by mail.

_____
Patient's Initials

You have the right to request restrictions on how protected health information may be used or disclosed for treatment, payment, or health care operations. We are not required to agree to your restrictions, but if we do, we are bound by our agreement with you.

_____
Patient's Initials

I hereby authorize Natural Eyes of Weston to release any of my treatment, payment, or health insurance information to the family member(s) and or friend(s) listed in the spaces provided. If no one is listed below, then none of this information will be discussed with anyone other than the patient.

_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Name	Relationship

By signing this form, you consent to our use and disclosure of protected health information about you for your treatment, payment, and health care operations. You have the right to revoke this consent in writing, except where we have already made disclosure in trust on your prior consent.

_____	_____
Patient Signature (or legal guardian)	Date