HARTSELLE EYE CARE

PRIVACY PRACTICES ACKNOWLEDGEMENT

I HAVE RECEIVED THE NOTICE OF PRIVACY PRACTICES AND I HAVE BEEN PROVIDED AN OPPORTUNITY TO REVIEW IT.

PATIENT
NAME _____ BIRTHDATE _____

I authorize Hartselle Eye Care to release information and/or materials to the following people:

_____

_____

_____

_____

PATIENT OR GUARDIAN
SIGNATURE _____

DATE _____