

NISWANDER EYE CENTER

**ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF
PRIVACY PRACTICES**

You may Refuse to Sign This Acknowledgment

I have received a copy of this office’s Notice of Privacy Practices.

Signature _____

Please Print Name _____

If signing for a minor, name of patient _____

Date _____

.....
I give my permission for the Niswander Eye Center to speak to the following person/people on my behalf:

Name Relationship

Name Relationship

Name Relationship

FOR OFFICE USE ONLY

Attempted to obtain written acknowledgment of receipt of Notice of Privacy Practices, but Acknowledgment could not be obtained because:

_____ Individual refused to sign

_____ Communication barriers prohibited obtaining the acknowledgment

_____ An emergency situation prevented obtaining acknowledgment

_____ Other:

(Explain) _____
