Eye Care & Vision Associates Ophthalmology, LLP

ACKNOWLEDGEMENT OF PRIVACY PRACTICES STATEMENT

OFFICE USE:

Patient Name: _____ ID #: _____

I hereby certify that I have been given the opportunity to review and/or receive a copy of the Practice's policy regarding protected health information in accordance with HIPAA regulations. A copy of this notice can be obtained at the office of Eye Care & Vision Associates or online at www.ecvaeyecare.com by clicking "Notice of Patient Privacy Policy" on the bottom left hand corner of the homepage.

Additionally, I give Eye Care & Vision Associates permission to discuss my medical condition with the following individual(s):

1) Name _____ Relationship _____ Phone _____

2) Name _____ Relationship _____ Phone _____

3) Name _____ Relationship _____ Phone _____

4) Name _____ Relationship _____ Phone _____

5) Name _____ Relationship _____ Phone _____

Signature _____ Date _____

Patient or individual authorized to give consent for Patient

_____

Print Name