Fichman Eye Center

Written Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: _____

Date of Birth: _____

I, _____, hereby acknowledge that I can request a copy of the Notices of Privacy Practices. I understand that if I have further questions I may contact the office manager at 860-649-9973.

I also understand that I am entitled to receive updates upon request if Fichman Eye Center and Laser Vision Surgery Center's Notice of Privacy Practices is amended or changed in a material way.

I authorize _____, my _____
to receive the information contained in my medical file either by phone or in writing
(example: wife, husband, son, daughter, sister, etc.)

_____
Signature of Patient

_____
Relationship to Patient

_____
Date

To be Completed by Covered Entity if Unable to Obtain Written Acknowledgement from Patient

On _____, I attempted to obtain a written acknowledgment of receipt of Notice of Privacy Practices from the above-named patient, but was unable to because:

[ ] Patient declined to sign this Written Acknowledgment

[ ] Patient did not understand the request to sign the Written Acknowledgment

[ ] Other (specify): _____

_____
Name and Title of Employee

_____
Date