ACNOWLEDGMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

This document is to be signed by a person legally responsible for the patient's medical decisions relative to the treatment situation.

I, ____________________________________, hereby acknowledge that Consulting Ophthalmologists, P.C. has provided me with a copy of its Notice of Privacy Practices that describes how medical information about me may be used and disclosed, and how I can access this information. I understand that if I have questions or complaints I may contact:

Medical Records Coordinator/Privacy Officer
(860) 678-0202

I also understand that I am entitled to receive updates upon request if Consulting Ophthalmologists, P.C. amends or changes its Notice of Privacy Practices in a material way.

________________________________ Signature

________________________________ Relationship to Patient, if signed by someone other than patient.

________________________________ Date

THIS SECTION IS TO BE COMPLETED BY CONSULTING OPHTHALMOLOGISTS, P.C. IF UNABLE TO OBTAIN WRITTEN ACKNOWLEDGMENT FROM PATIENT.

I made a good faith effort to obtain a written acknowledgment of receipt of the Notice of Privacy Practices from the above-named patient, but was unable to because:

[ ] Patient declined to sign this Written Acknowledgment.
[ ] Other (specify): ____

____ Name and title of employee

________________________________ Date