ACKNOWLEDGEMENT 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 the patient

_______________________________                          ______________________________
Date                                      Date

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

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

☐ Patient declined to sign this Written Acknowledgement

☐ Other (specify): ____________________________________________________________

_______________________________                          ______________________________
Name and Title of Employee                                      Date