



CONSULTING OPHTHALMOLOGISTS, P.C.
499 Farmington Avenue, Suite 100 295 Western Boulevard
Farmington, Connecticut 06032 Glastonbury, Connecticut 06033
Office Phone: (860) 678-0202
www.consultingeye.com

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

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