



EYE ASSOCIATES OF WILMINGTON, P.A.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By my signature below, I acknowledge that I have had an opportunity to review Eye Associates of Wilmington's Notice of Privacy Practices.

Patient's Name (Please Print)	Name of Legal Guardian (Please Print)
Patient's Signature (Please Sign)	Signature of Legal Guardian
Date	Date

There are occasions where Eye Associates of Wilmington may need to discuss my medical records with a representative designated by me. Please assist with your medical care by appointing one or more representatives below:

_____, Relationship _____ Phone _____

_____, Relationship _____ Phone _____

I prefer you not discuss my medical records with anyone but me _____
Patient Signature

I give my permission to leave positive test results / positive diagnosis on my answering machine.

Signature (Please Sign)

**This acknowledgement page should be retained in the patient's record.
If acknowledgement could not be obtained from the patient,
the reasons must be documented below.**

