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Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: ____

Patient Phone Number: ____

Signing this document signifies that you have read or received a copy of our Notice of Privacy Practices.

In order to provide a service to you, we create, store and receive health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, obtain payment and conduct health care operations at or for our office. The Notice of Privacy Practices that has been given describes uses and disclosures in detail.

I acknowledge that I have read or received the Notice of Privacy Practices from Matthew Y. Matsuzaki, O.D.

______________________________ ______________________________

Signature Date

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign:

______________________________ ______________________________

Relationship to Patient Date