



# Garrett Eye Clinic

**COMPLETE EYE CARE**

## Acknowledgement of Receipt of Notice of Privacy Practices

Print Patient Name: \_\_\_\_\_

Patient ID #: \_\_\_\_\_

I hereby acknowledge that I have received a copy of Garrett Eye Clinic's Notice of Privacy Practices. I understand that I have the right to refuse to sign this acknowledgement if I so choose.

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Patient's Representative (if applicable)

**Relationship to Patient (if applicable)**

- Parent or guardian of unemancipated minor
- Court appointed guardian
- Executor or administrator of decedent's estate
- Power of Attorney

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices on the following date,

\_\_\_\_\_ but acknowledgment could not be obtained because:

- Patient/representative refused to sign
- Emergency situation prevented us from obtaining acknowledgement at this time (will attempt again at a later date)
- Communication barriers prohibited obtaining acknowledgement (Explain)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

- Other (Specify)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_