

Great Lakes Eye Institute

**ACKNOWLEDGMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES**

The undersigned Patient or legally authorized representative ("Agent") of the Patient acknowledges that he or she personally received a copy of Great Lakes Eye Institute's Notice of Privacy Practices on the date indicated below.

Signature: _____ Date: _____

Patient: _____ DOB: _____

Information about Agent (attach appropriate documentation):

Agent: _____

Title: _____

I authorize Great Lakes Eye Institute to discuss with and release to the following any and all of my personal health information should Great Lakes Eye Institute not be able to reach me or as they deem necessary:

Name Relationship Phone Number

Name Relationship Phone Number

Name Relationship Phone Number

This authorization will remain in effect until written notification is given to Great Lakes Eye Institute terminating this authorization. This authorization does cover and include all Great Lakes Eye Institute offices.

Patient's Signature Date

FOR OFFICE USE ONLY

- G Patient/Representative Unable to Sign - Notice of Privacy Practices Provided
- G Patient/Representative Refused to Sign - Notice of Privacy Practices Provided
- G Other _____

Employee's Signature: _____ Date: _____

Employee's Printed Name: _____