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: _____