Acknowledgement of Privacy Notice (HIPPA)

I, *(please print name)* _____

Acknowledge that I have received a copy of Schoonover Eye Care's, P.C. Notice Regarding Privacy of Personal Health Information.

Name of the person(s) that you designate us to release information to (please note that if you do not wish to name anyone, and then only you can call to verify appointments, ask questions concerning your exam or your bill):

Name_____

Relationship_____

Phone (_____) _____

Name_____

Relationship_____

Phone (_____) _____

Date _____

Signature of Patient/Parent/Guardian_____

Guardian Name_____

Date_____ Witness Initial_____