

# NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I acknowledge that I have received a copy of the Medical Eye Center, Laser & Surgical Eye Center, Medical Eye Optical and The Spa Medford Notice of Privacy Practices.

**By signing below, I agree that I have received a copy of the Notice of Privacy Practices.**

_____	_____
Patient Signature	Date
_____	_____
Print Patient Name	Account #

**OR**

_____	_____
Parent, Guardian, Responsible Party, Legal Representative Signature	Date
_____	
Description of Representative's Authority	

Notice of Privacy Practices Acknowledgment

Form Effective: September 23<sup>rd</sup>, 2013