ANDROS GAGLIANI EYE CENTER
Dr. P. Andros-Andrzejewska
HIPAA PRIVACY
ACKNOWLEDGEMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I, _____ (Please print full legal name here - Patient or Patient's legal representative), have been presented with the Notice of Privacy Policy of ANDROS GAGLIANI EYE CENTER, and have been offered a copy of such policy to keep for my records.

_____ (Please initial here) I hereby acknowledge that I have been provided with a copy of the Policy.

- OR -

_____ (Please initial here) I hereby refuse to acknowledge receipt of the Policy. I understand that even though I may refuse to sign this acknowledgement, ANDROS GAGLIANI EYE CENTER may still provide treatment to me.

I have read the consent and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment, and health care operations.

_____

Signature of Patient Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ Patient or Patient's legal representative refused to sign.

_____ Communications barriers prohibited obtaining the acknowledgement.

_____ Emergency circumstances prevented securing acknowledgement.

_____ Other (Please specify) _____
_____
_____
_____

_____

Signature of Provider representative Date