OPHTHALMIC ASSOCIATES, a Professional Corporation
542 West Second Avenue, Anchorage, AK 99501
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, (Print Name) _____, acknowledge that I have received a copy of OPHTHALMIC ASSOCIATES' Notice of Privacy Practices.

_____ _____
Patient Signature Date

_____ _____
Patient Legal Representative (if applicable) Date

_____ _____
Print Name of Legal Representative Relationship to Patient

To authorize disclosure to family, friends or other individuals, please list all persons by full name authorized to receive disclosures, sign and date the form below:

_____

_____

_____ _____
Signature Date

This form will be retained with the patient's medical records.

For Office Use Only

OPHTHALMIC ASSOCIATES made the following good faith efforts to obtain the above-referenced individual's written acknowledgment of receipt of the Notice of Privacy Practices but an acknowledgment could not be obtained because:

___ Individual refused to sign

___ Communications barriers prohibited obtaining the acknowledgment

___ An emergency situation prevented us from obtaining the acknowledgment

___ Other (Please specify)
_____
_____