MOUNT VERNON EYE CARE, PC

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

("Acknowledgment")

I acknowledge that I have received a copy of Mount Vernon Eye Care, P.C. **HIPAA Notice of Privacy Practices.**

_____ _____

Patient Name (please print) Date

_____ _____

Patient Signature Signature of Personal Representative

Authority of Personal Representative to sign for patient (check one):

□ Parent □ Guardian □ Power of Attorney □ Other _____

Please Note: It is your right to refuse to sign this Acknowledgment.

- -

Office Use Only

I tried to obtain written Acknowledgment by the individual noted above of receipt of our **Notice of Privacy Practices**, but it could not be obtained because:

□ An emergency prevented us from obtaining acknowledgment.
□ A communication barrier prevented us from obtaining acknowledged.
□ The individual was unwilling to sign.
□ Other : _____

_____ _____

Staff Member Signature Date