**Sharper eyecare**

**Notice of Privacy Practices**

**Acknowledgment of Receipt of**

**the notice of privacy practices of**

**Sharper eyecare**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**By signing this document, I acknowledge that I have received a copy of Sharper Eyecare’s Notice of Privacy Practices.**

I agree to allow Sharper Eyecare to send a reminder regarding any future appointments. Such information will be mailed, emailed and/or otherwise delivered in an envelope, postcard, container or electronic communications method that may contain the name of Sharper Eyecare and/or an individual physician providing care at Sharper Eyecare.

*Please initial here if you prefer* ***NOT*** *to have a reminder sent to you:* \_\_\_\_\_\_\_

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. If changes occur, this practice will provide me a revised Notice of Privacy Practices upon request.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to patient (if signed by a personal representative of patient): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_