SEDALIA EYE ASSOCIATES, P.C.

ACKNOWLEDGEMENT: RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have been offered a copy of Sedalia Eye Associates, P.C.'s Notice of Privacy Practices effective April 1, 2014. (A copy will be available at our office for your review. You may choose to sign this form after you have viewed the Notice if you prefer.)

I authorize Sedalia Eye Associates, P.C. to provide the following individual(s) with information about my medical care provided by Sedalia Eye Associates, P.C.: (optional)

Name_____ Name_____
Phone Number_____ Phone Number_____
Relationship to Patient_____ Relationship to Patient_____

This consent expires:
□ never □ on a specific date (write in date desired)_____
□ when a specific event takes place (write in specific event)_____

_____ _____ _____
Printed Name Signature Date

Relationship to Patient: □ Self □ Parent □ Legal Guardian

FOR OFFICE USE ONLY:
If the individual or parent/legal guardian did not sign above, staff must document when and how the Notice was given to the individual, why the acknowledgement could not be obtained, and the efforts that were made to obtain it.

Notice of Privacy Practices effective April 1, 2014 given to individual on _____(date).
Reason individual or parent/legal guardian did not sign the form:

□ did not want to □ did not respond after more than one attempt □ other_____

The following good faith efforts were made to obtain the individual or parent/legal guardian's signature. Please document with dates, times, individuals spoken to, and outcome, as applicable, the efforts that were made to obtain the signature. More than one attempt must be made.

□ in person conversation_____ □ Telephone contact_____
□ mailing_____ □ Other_____

_____ _____ _____
Printed Staff Name Staff Signature Date