RGB
CATARACT & LASIK

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ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

I received and reviewed this office's Notice of Privacy Practices which explains how my medical information will be used and disclosed.

You may release medical information to the person(s) listed below. I understand it is my responsibility to inform you in writing if an individual needs to be removed from this list.

_____
First and Last Name

_____
First and Last Name

_____
First and Last Name

_____
First and Last Name

_____ _____
Signature of Patient Date

If you are the patient's legal guardian, please fill out below:

_____
Name of Patient

_____
Print Personal Representative Name and Relationship

_____ _____
Personal Representative Signature Date