MOLLICK PROFESSIONAL CENTER
EYE EXAMINATIONS AND CONSULTATIONS

PERRY S. MOLLICK, M. D., F.A.A.O.
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PERRY MOLLICK, M.D., P.C.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, (print Patient's name) _____, acknowledge and agree that I have received a copy of Perry Mollick, M.D., P.C.'s Notice of Privacy Practices.

_____ _____
Patient Signature Date

_____ _____
Patient Legal Representative (if applicable) Date

_____ _____
Print Name of Legal Representative Relationship to Patient

I authorize the disclosure if my private health insurance information to the following people:

Name	Relationship	Phone#

FOR PRACTICE USE ONLY:

Perry Mollick, M.D., P.C. made the following good faith efforts to obtain the above-referenced Patient's written acknowledgement of receipt of the Notice of Privacy Practices:

[Identify the efforts that were made to obtain the individual's written acknowledgement, including the reasons (if known) why the written acknowledgement was not obtained.

Examples:

- **Patient was asked to sign upon check-in but refused to do so**
- **Because of medical condition, Patient physically unable to sign acknowledgement**
- **etc.]**