ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have reviewed or been given a copy of this practice's Notice of Privacy Practices, which provides me a complete description of the uses and disclosures of certain health information. I understand that I am entitled to receive a copy of this document.

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 is maintained. I understand that I can obtain this practice's current Notice of Privacy Practices upon request.

Signature _____ Date _____

Name of Patient or Personal Representative

Relationship to Patient *(If signed by a personal representative of patient)* _____

The following persons can have access to my protected health information on a routine basis. I give permission for Paragon Eye Associates to share my protected health information with:

_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Name	Relationship