PRIMARY EYECARE CENTER AN OPTOMETRIC PRACTICE
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PRIMARY EYECARE CENTER
An Optometric Practice

Acknowledgment Of Privacy Practices

Date: _____

I, _____ acknowledge that I have received a copy of the Notice of Privacy Practices from PRIMARY EYECARE CENTER (AT).

I have listed individuals that are authorized to receive my protected health information. I am aware that I can revoke the authorization for any individual at any time, but must do so in writing.

_____ _____
Signature of Patient Date

_____ _____
Signature of Patient Representative & Relationship Date
(Required if patient is a minor or an adult unable to sign form)

The following individuals have my authorization to access my Protected Health Information

Name	Relationship	Date of Birth
Name	Relationship	Date of Birth
Name	Relationship	Date of Birth
Name	Relationship	Date of Birth