TOTAL EYECARE

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Acknowledgment of Receipt of Notice of Privacy Practices and Designation Disclosure Form

- Hereby authorize **Total Eyecare** to release the complete history/records to the following:

Name: ____ Relationship: ______________________________

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Name: ____ Relationship: ______________________________

Patient Contact:

- Appointment reminders, test results, billing and orders purchased will be made to your home phone, cell phone and/or email.

Phone Number: ________________________________ Cell Number: ______________________________

Email: ____

____ Do not leave a message on my voicemail.

- I hereby acknowledge that I have been informed and presented with a copy of **Total Eyecare's** privacy policy.

Patient Name: ____

Parent/Guardian: ____

Signature: ____ Date: ____________________

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For Office Use only:

Form Received By: __________________________ (Employee Signature) Date: ____________________

Acknowledgement refused by patient: Yes ______ No _____