

# TOTAL EYECARE

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## Acknowledgement of Receipt of Notice of Privacy Practices and Designation Disclosure Form

- I hereby authorize Total Eyecare to release the complete history/records to the following:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

### Patient Contact:

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

Home Number: \_\_\_\_\_ Cell Number: \_\_\_\_\_

Email: \_\_\_\_\_

- I hereby acknowledge that I have been presented a copy of Total Eyecare's privacy policy. ( You may find a copy on our website )

Patient Name: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_