# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

PATIENT NAME _____ DATE OF BIRTH _____
(FIRST) (MIDDLE INITIAL) (LAST)

By signing below, I acknowledge that I have received Highland Retina Associates, LLC's Notice of Privacy Practices.

_____ _____
SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE

_____ _____
(PRINTED NAME IF LEGAL GUARDIAN) RELATIONSHIP TO PATIENT

***Office Use:***

*This acknowledgement page should be retained in patient record. If acknowledgement could not be obtained from the patient, the reason(s) must be documented below:*

_____ PATIENT DECLINED

_____ OTHER REASON (DESCRIBE BELOW):

_____

_____

_____

_____

_____ _____
EMPLOYEE SIGNATURE DATE

_____
EMPLOYEE PRINTED NAME