

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

Pediatric Ophthalmology Consultants, L.L.C reserves the right to modify the privacy practices outlined in the notice.

I have received a copy of the Notice of Privacy Practices for  
**PEDIATRIC OPHTHALMOLOGY CONSULTANTS, L.L.C.**

\_\_\_\_\_  
PATIENT NAME (PRINT OR TYPE)

\_\_\_\_\_  
PATIENT SIGNATURE

\_\_\_\_/\_\_\_\_/\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE OF PATIENT REPRESENTATIVE  
(REQUIRED IF THE PATIENT IS A MINOR OR AN ADULT WHO IS UNABLE TO SIGN THIS FORM)

\_\_\_\_/\_\_\_\_/\_\_\_\_  
DATE

\_\_\_\_\_  
RELATIONSHIP OF PATIENT REPRESENTATIVE TO PATIENT

**DOCUMENTATION OF ATTEMPT TO OBTAIN  
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

**ATTEMPT TO OBTAIN ACKNOWLEDGEMENT**

An attempt was made to obtain an acknowledgement of receipt of the Notice of Privacy Practices on \_\_\_\_\_. The acknowledgement was not obtained because:

- The patient was undergoing emergency treatment
- The patient declined to sign the acknowledgement
- Other \_\_\_\_\_

\_\_\_\_\_  
STAFF SIGNATURE

\_\_\_\_/\_\_\_\_/\_\_\_\_  
DATE

