Acknowledgement of Receipt of Notice of Privacy Practices

Windham Eye Group, P.C.
83 Quarry Street Willimantic, CT 06226
Office Manager, 860-423-1619

Name of Patient:

_____

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I may request a copy of any amended Notice of Privacy Practices at each appointment.

Signed:_____Date:_____

Print Name: _____

Telephone: _____

We cannot discuss your protected health information (PHI) with anyone other than yourself unless you authorize us to do so. Please list below any names of individual(s) you authorize our office to discuss your care with. Your PHI may be disclosed to the individual(s) listed below until you notify us otherwise in writing.

1_____2. _____

3._____

If not signed by the patient, please indicate your relationship to the patient:

_____

For Office Use only:

Signed form received by:

_____

Acknowledgment refused.

Reason for refusal_____