Eye Care Associates
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**Drs. Thomas E. McCarthy, Jason C. Eubank,
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Acknowledgement of Receipt of Notice of Privacy Practices

PATIENT NAME

PATIENT NUMBER

PATIENT PHONE NUMBER

PATIENT ADDRESS

Signing this document signifies that you have received a copy of our Notice of Privacy Practices.

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct healthcare operations involving our office. The ***Notice of Privacy Practices*** you have been given describes these uses and disclosures in detail.

I ACKNOWLEDGE THAT I HAVE RECEIVED THE NOTICE OF PRIVACY PRACTICES FROM EYE CARE ASSOCIATES.

SIGNATURE ______________________________ DATE

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form:

RELATIONSHIP TO PATIENT

PRINT NAME

SOURCE OF AUTHORITY

ADDRESS

PHONE NUMBER