NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGEMENT OF RECEIPT

DATE:_____

I acknowledge that I was provided with a copy of the Foulkes Vision Institute Notice of Privacy Practices.

_____ _____
Patient Name (Print) Patient Signature

If completed by a patient's personal representative, please print and sign your name in the space below

_____ _____
Personal Representative (Print) Personal Representative's Signature

_____
Relationship

For Foulkes Vision Institute use only.
Complete this section if this form is not signed and dated by the patient or patient's representative.
I have made a good faith effort to obtain a written acknowledgement of receipt of Foulkes Vision Institute's Notice of Privacy Practices but was unable to for the following reason:

□ Patient refused to sign
□ Patient unable to sign
□ Other _____

_____ _____
Employee Name Date

This form should be placed in the patient's medical record