ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
California Eye Clinic

3747 Sunset Lane
Antioch, CA 94509
(925) 754-2300

1181 Central Blvd., Suite F
Brentwood, CA 94513
(925) 516-0888

2260 Gladstone Drive, Suite 3
Pittsburg, CA 94565
(925) 427-2111

301 Lennon Lane, Suite 201
Walnut Creek, CA 94598
(925) 932-1123

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 will be offered a copy of any amended Notice of Privacy Practices

Signed._____ Date: _____

PrintName: _____ Telephone: _____

if not signed by the patient, please indicate:
Relationship:

☐ parent or guardian of minor patient
☐ guardian or conservator of an incompetent patient
☐ beneficiary or personal representative of deceased patient

Name of Patient:_____

NOTICE OF PRIVACY PRACTICES (Acknowledgements Tracking Information)

Name of Patient:_____

Address._____

_____

complete the following only if the Patient refuses to sign the Acknowledgement·

Efforts to obtain._____

_____

Reasons for refusal._____

_____