THE MIDWEST CENTER FOR SIGHT

Health Insurance Portability and Accountability Act
Patient Acknowledgement

I hereby acknowledge that I have received Notice of Privacy Practices of The Midwest Center for Sight.

I also authorize the Midwest Center for Sight to discuss my medical care with the following person(s):

____ ____________________________
Name **Relationship**

____ ____________________________
Name **Relationship**

I am not authorizing release of information to anyone other than my doctor. ☐

This authorization is in effect until I notify The Midwest Center for Sight in writing advising otherwise. This acknowledgement was signed by:

____
Print Name – Patient or Personal Representative

X____ ________________________________
Signature of Patient or Personal Representative **Date**

____
Relationship to Patient (if other than patient)

(FOR OFFICE USE ONLY IF PATIENT DOES NOT SIGN ABOVE)
DOCUMENTATION OF GOOD FAITH EFFORTS TO OBTAIN ACKNOWLEDGEMENT

Patient Name: ____**Date**__________________________

The Patient presented for service on the date set forth above and was provided with a copy of the Notice of Privacy Practices ("Notice"). A good faith effort was made to obtain the Patient's written acknowledgement of receipt of the Notice. However, an acknowledgment was not obtained for the following reason(s):

- ☐ **Patient refused to sign acknowledgement.**
- ☐ **Patient was unable to sign the acknowledgement because:**
  ____
  ____
- ☐ **Other reason (describe below):**
  ____
  ____

Name of Employee Completing Form: ____________________________

Signature:____
Date: ____