

Coastal Cape Fear Eye Associates, PA

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, have received a copy of this office's Notice of Privacy Practices. I am the patient, parent, legal guardian, or have Power of Attorney for this patient and am signing on their behalf.

(Please Print Patients' Full Name)

(Signature of Patient, Parents', Legal Guardian, or have Power of Attorney)

(Date)

Please give us your mothers' first name for identification purposes when you call our office.

(Please Print Mothers' First Name), this will be used to identify you when calling our office for information.

For Office Use Only

- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)
