EYE SURGERY CENTERS OF NEW YORK

RECEIPT

RECEIPT OF NOTICE OF PRIVACY PRACTICES (VERSION PN-2, 3/29/03) IS HEREBY ACKNOWLEDGED:

_____ _____

SIGNATURE OF PATIENT/GUARDIAN PRINT NAME

_____

DATE

If signed by guardian or Power of Attorney, name of patient:

_____

The patient, or person signing for the patient named above, acknowledges receipt of federally- required Notice of Privacy Practices, provided to you under the provisions of the Health Insurances Portability and Accountability Act of 1996. The notice describes how medical information about you (or the patient, if you are someone signing for the patient) may be used and disclosed, and how you can get access to information. You also have certain other privacy rights under federal law, and these rights are described more fully in the notice. You have been given a copy to take with you. Please review it carefully. The Notice helps you understand all the uses and disclosures that may be made of your medical information, and it describes your privacy rights. The Notice also indicates who you should contact if you have questions about privacy rights. This receipt will be kept in your patient record to document that you have received this required notice.