

LAKE OPTICAL, INC.
2 W. GRAND AVENUE – SUITE 107
FOX LAKE, ILLINOIS 60020
847-587-0901

PATIENT NAME _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

(You May Refuse to Sign This Acknowledgement)

I acknowledge that I was offered a copy of the Notice of Privacy Practices and that I have read (or have had the opportunity to read) and understood the Notice.

Patient/Parent/Legal Guardian Signature _____ Date _____

Pursuant to keeping your personal health information private, please provide us with the following information.

1. Preferred contact phone number: _____.
2. May we leave a message with other residents? YES NO
3. May we leave a message on your answering machine/voicemail? YES NO

To whom may we talk to about your medical treatment and/or release product to?

1. Name _____ Relationship _____

Phone number: Home _____ Cell _____

Other _____

2. Name _____ Relationship _____

Phone number: Home _____ Cell _____

Other _____

If any of the above information changes, it is the Patient/Parent/Legal Guardian's responsibility to contact our office.

Patient/Parent/Legal Guardian Signature _____ Date _____

OFFICE USE ONLY:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained

because: -Refusal to sign

- Communication Barriers existed

- Emergency situation prevented us from obtaining acknowledgment

- Other: _____

