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### Acknowledgement Of Privacy Practices

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Date

I, \_\_\_\_\_ acknowledge that I have received a copy of the Notice of Privacy Practices from Putnam Parkway Eyecare.

I have listed individuals that are authorized to receive my protected health information. I am aware that I can revoke the authorization for any individual at any time, but must do so in writing.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient Representative & Relationship  
(Required if patient is a minor or an adult unable to sign form)

\_\_\_\_\_  
Date

**The following individuals have my authorization to access my Protected Health Information**

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Phone

**EMERGENCY CONTACT NAME/NUMBER**