Temas Eye Center
Acknowledgement of Receipt of Privacy Notice

I understand that as a healthcare provider, my physician or the practice's staff may share my medical information for treatment, billing and healthcare business purposes. I acknowledge that I have been given information that describes how my medical information is used and shared. I understand the organization has the right to change the Privacy Notice at any time. I may obtain a current copy of the notice by contacting the Temas Eye Center at 336-659-8180 or by visiting the web site at www.temaseye.com

My signature below constitutes my acknowledgement that I have been provided with a copy of the notice of privacy practices:

- ____ ____________________
  Signature of Patient or Legal Representative Date

If signed by a legal representative, relationship to the patient:

____

- **Temas Eye Center has my permission to provide any medical information to the following individuals (example: spouse, daughter, son…)**

  ____ Spouse ____ Answering machine/Voice mail ____ Children _____ Self only

  ____ Other____

Please complete following if unable to secure written acknowledgement of receipt of notice.

I was unable to secure a written Acknowledgement of Receipt of Privacy Notice because:

____ Patient is comatose and no legal representative available to sign

____ Other reason:

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Signature of provider/employee Date

__________________________________ _________________________

Form rev. 7/2012