Davis Optical and Family and Eye Health Center
Receipt of Notice of Privacy Practices Written Acknowledgement

I have received the Notice of Privacy Practices and have been provided an opportunity to review it.

____________________________________ ____________________________________
Signature of Patient or Guardian | Date

____________________________________ ____________________________________
Print Patient Name | Patient Date of Birth

May we leave confidential medical information (such as diagnosis and treatment information) on your phone message system?

______**YES**, you may leave a message with confidential information at:

____________________________________ ____________________________________
HOME PHONE NUMBER | CELL PHONE NUMBER

______**NO**, please do NOT leave any messages on my phone systems

May we discuss confidential medical information with any other person who may answer the phone at your number?

_____**YES**, you may leave a message and/or discuss confidential medical information with

____
NAME/RELATIONSHIP (i.e. John/husband)

_____**NO**, please DO NOT discuss any medical information with anyone at my phone number but me.

NOTE: please let us know IMMEDIATELY if any of these authorizations and/or phone numbers changes so we can update this information.

This form will be kept as part of the medical record.