Shillington Eye Associates, LLC
453 East Lancaster Avenue, Shillington, Pa 19607
(610) 775-3321

Patient Name (Print) _____Date _____

Notice of Privacy Practices Acknowledgement Form

I hereby acknowledge that I have received/refused a copy of the Shillington Eye Associates Notice of Privacy Practices. I understand that I am to review the policy and any questions or comments related to the Notice of Privacy Practices policy should be directed to the office manager.

Patient/Patient Representative Signature_____

Patient Representative's Relationship to Patient_____

I hereby authorize the release of all medical, financial, and/or demographic information to:

_____ Relationship _____

_____ Relationship _____

I acknowledge that I have reviewed the Shillington Eye Associates, LLC HIPPA Practices

Date _____ Patient/Representative Signature_____ Relationship_____

Date _____ Patient/Representative Signature_____ Relationship_____

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