

Manchester Ophthalmology

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PRIVACY PRACTICES ACKNOWLEDGEMENT

Name: _____ **Date of Birth:** _____

I have received the Notice of Privacy Practices. I wish to be contacted in the following manner (*check all that apply*):

- Home/Cell Phone: _____
 - O.K. to leave appointment information on voice mail
 - O.K. to leave detailed information on voice mail
 - Leave message with call-back number only.

- Work Phone: _____
 - O.K. to leave detailed information on voice mail
 - Leave message with call-back number only.

My medical records may be discussed with the following family/friend(s). (*Please list anyone you would like us to be able to leave a message with or discuss your medical information with*):

- Spouse/Significant Other – Name: _____
- Others: _____

Signature: _____ **Date:** _____

Updated: Date _____ **Initials** _____