Harris EYE CARE

Dr. Timothy Harris, OD, PLC

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgment.

Please fill out completely using black ink only.

I, _____, HAVE RECEIVED A COPY OF THE NOTICE OF PRIVACY PRACTICES FOR THE OFFICE OF HARRIS EYE CARE.

_____ _____

Patient or Personal Representative Signature *Relationship

_____

Date

**If personal representative's signature appears above, please describe relationship to patient.*

We attempted to obtain acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

____ Individual refused to sign
____ Communication barriers prohibited obtaining the acknowledgment
____ An emergency situation prevented us from obtaining acknowledgment
____ Other (*please specify*)

_____
_____
_____
_____

_____

Employee's Name Printed

_____ _____

Employee's Signature Date

1016 S. State Road
Davison, MI 48423
(810) 653-3206