Acknowledgment of Notice of Privacy Practices

Golebiowski Eye Care
179 Great Rd. Suite 111A
Acton, MA 01720

This law requires that Golebiowski Eye Care make every effort to inform you of your rights related to your personal health information. By signing below, I acknowledge that:

I have reviewed the HIPAA Notice of Privacy Practices, have been provided an opportunity to discuss my right to privacy, and know that upon request I will be given a copy of the notice.

I authorize Golebiowski Eye Care to release my personal health information to the following individuals.

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I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

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Patient Signature Date

If you are signing as a personal representative of the patient, please indicate your relationship. If you are signing for a minor, you attest that you have the legal authority to make medical decisions for the minor and consent to such care. Please indicate any other parent, step-parent or guardian or other individual (s) authorized to make medical decisions for the minor.

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Representative Signature Relationship to Patient