

## ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have been presented and/or read SNEED EYE ASSOCIATE'S Privacy Notice detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Privacy Notice and I request the following restriction(s) concerning the use of my personal medical information:

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This acknowledgment should be retained in patient's record. If acknowledgment cannot be obtained from patient, the reasons must be documented below:

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## AUTHORIZATION FOR RELEASE OF MEDICAL OR FINANCIAL INFORMATION

Please list below any person(s), in addition to your health care provider(s) and their practice(s) or your insurance company(s), you are authorizing to receive or discuss medical records or financial information regarding your patient records with SNEED EYE ASSOCIATES:

NAME:	RELATIONSHIP TO PATIENT:

## CELL PHONE ACKNOWLEDGMENT

Our doctors have asked that each patient and family members, caregivers or transportation service providers turn all cell phones **off** during their visits at our office, except while in the patient reception area. We appreciate your cooperation regarding this matter.

SIGNED: \_\_\_\_\_ DATE: \_\_\_\_\_