

STRECKER EYE CENTER

Richard W. Strecker, M.D.

RECEIPT OF NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

I hereby acknowledge that on _____ I received Strecker Eye Center's Notice of Privacy Practices, which sets forth the ways in which my personal health information may be used or disclosed by Strecker Eye Center, and outlines my rights with respect to such information.

Patient's signature or authorized representative

In the case of an emergency when the patient is not able to sign the acknowledgement form, attempt to obtain the patient's signature as soon as possible. If you are unable to obtain a signature for any reason, document the attempts made to obtain the signature and the reasons why you were unsuccessful below:
