ROCHELLE EYE CARE CENTER
DR. JOHNSON & DR. MLSNA
719 LINCOLN AVE
ROCHELLE, IL 61068

ACKNOWLEDGMENT OF RECEIPT of the Notice of Privacy Practices of the ROCHELLE EYE CARE CENTER

I acknowledge that I have received or been offered the Notice of Privacy Practices of the Rochelle Eye Care Center. I understand that the Notice describes the uses and disclosures of my protected health information by the Covered Entities which collectively constitute the Rochelle Eye Care Center and informs me of my rights with respect to my protected health information.

_____

Name of Patient

_____

Date of Birth

_____

Signature of Patient or Personal Representative

_____

Printed Name of Patient or Personal Representative

_____

Date

If Personal Representative, indicate relationship:

_____

Declinations

☐ The Individual declined to accept a copy of the Notice of Privacy Practices.

☐ The Individual received a copy of the Notice of Privacy Practices but declined to sign an Acknowledgment of Receipt.

_____ _____

Signature of Rochelle Eye Care Center Representative Name of Rochelle Eye Care Center Representative