

F. Y. Eye Care Associates
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ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Notice of Privacy Practices from F. Y. Eye Care Associates

I have listed individuals that are authorized to receive my protected health information. I am aware that I can revoke the authorization for any individual at any time, but must do so in writing.

Signature of Patient

Date

Signature of Patient Representative & Relationship
(Required if patient is a minor or an adult unable to sign form)

Date

The following individuals have my authorization to access my Protected Health Information

Name

Relationship

Date of Birth

Name

Relationship

Date of Birth

Name

Relationship

Date of Birth

Name

Relationship

Date of Birth