Acknowledgement of Receipt of Notice of Privacy Practices

THE EYE DOCTOR UNLIMITED / Dr. Leah J. McFerren
1704 Virginia Avenue
College Park, Georgia 30337
404-768-3500

Patient Name: ____

Signing this document signifies that you have received a copy of our Notice of Privacy Practices.

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct healthcare operations involving our office. The ***Notice of Privacy Practices*** you have been given describes these uses and disclosures in detail.

I acknowledge that I have received the *Notice of Privacy Practices* from The Eye Doctor Unlimited.

______________________________________ ______________________

Signature of Patient or Legal Guardian Date