

# 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

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**OFFICE USE ONLY**

I attempted to obtain the patient's signature on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: \_\_\_\_\_ Initials: \_\_\_\_\_

Reason: \_\_\_\_\_  
\_\_\_\_\_  
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