ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

By signing this form, you are agreeing that you have received a copy of the idoc Optical Privacy Notice, which describes how we use and disclose your health information. You have the right to refuse to sign this Acknowledgment, in which case we must document our good faith effort to obtain your acknowledgment and the reason why it was not obtained.

Receipt of Privacy Notice acknowledged by:

Signature	Date	Print Name

Relationship to patient: ☐ Self ☐ Other: _____

PATIENT, SPOUSE, LEGAL REPRESENTATIVE, OR BENEFICIARY (PATIENT'S SPOUSE MAY AUTHORIZE DISCLOSURE OF PATIENT'S HEALTH INFORMATION ONLY WHEN THE HEALTH INFORMATION IS FOR THE SOLE PURPOSE OF PROCESSING AN APPLICATION FOR HEALTH INSURANCE, FOR ENROLLMENT IN A HEALTH CARE SERVICE PLAN OR AN EMPLOYEE BENEFIT PLAN, AND WHERE PATIENT IS TO BE AN ENROLLED SPOUSE OR DEPENDENT UNDER THE POLICY OR PLAN)