Retina-Vitreous
Surgeons of Central NY,PC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

PATIENT NAME _____ DATE OF BIRTH _____
(FIRST) (MIDDLE INITIAL) (LAST)

By signing below, I acknowledge that I have received Retina-Vitreous Surgeons of Central NY, PC's Notice of Privacy Practices.

_____ _____
SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE

_____ _____
(PRINTED NAME IF LEGAL GUARDIAN) (RELATIONSHIP TO PATIENT)

Office Use:
This acknowledgement page should be retained in patient record. If acknowledgement could not be obtained from the patient, the reason(s) must be documented below:

_____ PATIENT DECLINED

_____ OTHER REASON (DESCRIBE BELOW):

_____

_____

_____

_____

_____ _____
EMPLOYEE SIGNATURE DATE

_____
EMPLOYEE PRINTED NAME

Syracuse
3107 East Genesee Street
Syracuse, NY 13224
(315) 445-8166

Watertown
400 Washington Street
Watertown, NY 13601
(315) 782-0492

Binghamton
4104 Vestal Road, Suite 103
Vestal, NY 13850
(607) 729-4985