GEORGIA VISION INSTITUTE
GEORGIA CATARACT AND EYE SPECIALTY CENTER

PATIENT ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

Patient's Name_____ DOB_____

I hereby authorize Georgia Vision Institute and Georgia Cataract and Eye Specialty Center (GVI) to use my protected health information to provide healthcare, to handle billing and payments, and to take care of other health operations.

GVI has a document called the Notice of Privacy Practices, available for review at our office, as well as online at our website. It contains additional information about the policies and practices that protect a patient's privacy. I understand that I have the right to read this Notice before signing this Acknowledgement.

I also authorize GVI staff to discuss my personal health information (appointment information, test results, billing/insurance information, or discussions regarding my general care) with the following individual(s):

Name	Relationship	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____ _____
Patient or Guardian's Signature Date

_____ _____
Name of Guardian or Personal Representative Relationship to Patient