PHYSICIANS EYE CARE CENTER
11055 Little Patuxent Parkway
Columbia MD 21044
(410) 964-8285

Notice of Privacy Practices
Patient Acknowledgment

Patient Name:_____

Date of Birth:_____

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail uses and disclosures of may protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. I understand and have obtained this practice's current Notice of Privacy Practices.

Signature: _____

Date: _____

Relationship to patient (if signed by a personal representative of patient):

_____