ACKNOWLEDGEMENT
OF
NOTICE OF PRIVACY PRACTICES

The law requires that Goldsmith Eye Care PC make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

I acknowledge that I have been given the opportunity to read and/or had explained to me and/or receive Goldsmith Eye Care PC's Notice of Privacy Practices. I wish to continue my care with Goldsmith Eye Care PC under the terms of Goldsmith Eye care PC's privacy policies. I understand this form. I am signing it voluntarily.

I authorize Goldsmith Eye Care PC to release any medical information to other providers who are involved in my treatment.

The authorization and assignment will remain in effect until revoked by me in writing.

The following person(s) have my permission to discuss health and financial information on my behalf (optional)

_____ _____

_____ _____

_____ _____

Patient Date

If you are signing as a personal representative of the patient, please indicate your relationship

_____ _____

Representative Relationship to Patient