

Acknowledgement of Receipt of Notice of Privacy Practices

Anthony P. Giannotti, O.D.
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{ Affix patient label }

Signing this document signifies that you have read a copy of our Notice of Privacy Practices

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services and to conduct healthcare operations involving our office. The *Notice of Privacy Practices* you have read describes these uses and disclosures in detail.

I acknowledge that I have read the *Notice of Privacy Practices** from Anthony P. Giannotti, O.D.

Signature

Date

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form.

Signature

Date

Source of authority: _____

*copy available on request