

Richmond Eye Associates, P.C.

**Notice of Privacy Practices
Written Acknowledgement Form**

I, _____
(patient's printed name)

have been provided a copy of Richmond Eye Associates' Notice of Privacy Practices and I have had an opportunity to read the Notice.

I authorize Richmond Eye Associates to release my personal health information to the following individual(s) (Please Print). You may list as many individuals as you wish:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

I understand that I may change this list at any time.

Patient Signature

Date