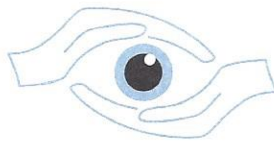

ANNE ARUNDEL FAMILY EYE CARE
Vincente Simoncini, O.D.

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received (or have been offered) a copy of Anne Arundel Family Eye Care's Notice of Privacy Practices. By signing this form, I am giving the office my consent to use and disclose health information about me for treatment, payment, and health care operation purposes.

Signature: ______________________________

Patient Name: ______________________________

Date: ______________________________

Dependent family members also covered by this acknowledgement:

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I authorize the following people to have access to my optometric records:

Parent/Guardian: ______________________________

Spouse/Partner: ______________________________

Relative: ______________________________

Other: ______________________________

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