LUGENE
EYE INSTITUTE

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

I hereby acknowledge that I have received a copy from LUGENE EYE INSTITUTE, the ***"Notice of Privacy Practices"***. I further acknowledge that a copy of this notice is posted in the reception area, and that I may request a copy of any amended "Notice of Privacy Practices".

Patient's Name: _____

Signed: _____ Date: _____
Patient or Authorized Representative

Print Name: _____ Relationship: _____
Person Signing (If other than Patient)

IF NOT signed, please indicate reason:

_____

_____

Date: _____