ACKNOWLEDGMENT OF RECEIPT
OF NOTICE OF PRIVACY PRACTICES

By signing below I acknowledge that I have received a copy of this office's Notice of Privacy Practices Form.

WITNESSES:

________________________________ ________________________________
Patient Signature

________________________________ ________________________________
Date

Documentation of Failure to Obtain Signed Acknowledgement

On ________________, __________________ presented this Acknowledgment of Receipt of Notice of Privacy Practices Form to _______________ (the "Patient"). The Patient refuses to provide a signature when requested.

Quality Eye Care, P.C.
Vincent C. Yu, M.D.
23550 Park St. Suite 200
Dearborn, MI 48124
313-724-CARE (2273)

PERMISSION TO GIVE MEDICAL INFORMATION

I,____, hereby authorize the physicians and staff of Quality Eye Care, P.C., to give the following people information concerning my health and well-being.

_____Spouse

____
Name

_____Significant Other

____
Name

_____Any Other Specified Person

____
Name and Relationship

_____Leave Message on Answering Machine
Home / Work (Please circle)

_____**I do not authorize the release of any medical information.**

The following information may be given to the above:

_____Appointment Times

_____Test Results

_____Medications

_____Procedures

_____Financial Information (Billing, Insurance etc...)

_____Any other information regarding my health

If delay in treatment results because we cannot relay information to another person, Quality Eye Care, P.C. will not be held responsible.

____

Signature of Patient, Parent/Legal Guardian Date