ACKNOWLEDGEMENT OF RECEIPT OF

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided by Charlotte Optometric Eye Clinic (COEC) Notice of Privacy Practices ("Notice"):

- It tells me how (COEC) will use my health information for the purposes of my treatment, payment for my treatment, and COEC health care operations.
- The Notice explains in more detail how COEC may use and share my health information for other than treatment, payment, and health care operations.
- COEC will also use and share my health information as required/permitted by law.
- If I am a patient of COEC receiving health services, I consent of COEC using and disclosing my treatment and health records maintained by COEC for the purposes detailed in COES's Notice of Privacy Practices.

Patient's Complete Legal Name: ____

(please print)

Patient's Date of Birth: _________________________ Date: ________________________________

Signature: ____

(Patient or legal representative*) *May be requested to show proof of representative status