WEST MICHIGAN
Eye & Laser

1450 E Farr Rd Suite 1000 Norton Shores, MI 49444
Phone: 231-737-9378 Fax: 231-737-1023

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICE

I hereby acknowledge that I understand this medical practice's Notice of Privacy Practices.

I further acknowledge that a copy of the current notice is available at the front desk.

For questions or concerns please contact the office.

In summary, this notice:

1. Outlines to whom we may legally disclose your health information, including your health insurance plan so that we may obtain payment for our services
2. States that we will not disclose your health information in any other way without your written authorization
3. Outlines your rights as a patient, including the
    - right to limit what information is disclosed
    - right to request confidential communication
    - right to inspect and copy your record
    - right you amend your records
    - right to receive copy of the "Notice of Privacy Practices"
4. Gives us the permission to change our "Notice of Privacy Practices" at any given time in the future, at which point you will be notified again
5. Informs you how to handle a complaint if you feel your privacy has been violated

Your signature on the form simply acknowledges you understand our privacy practices.

Signed:_____ Date:_____

Printed Name:_____ Telephone:_____

If not signed by the patient, please indicate your relationship:_____

Name of patient:_____