ACKNOWLEDGEMENT
OF
NOTICE OF PRIVACY PRACTICES

The law requires that West Georgia Eye Care make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

I have received a copy of West Georgia Eye Care's Notice of Privacy Practices. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services and conduct healthcare operations involving our office. The Notice of Privacy Practices you have been given describes these uses and disclosures in detail. You can get an updated copy here at the office or on our website, www.westgaeyecare.com.

I acknowledge that I have received the Notice of Privacy Practices from West Georgia Eye Care, P.C. and agree to the use and disclosure of health information that this document describes in detail. I authorize the doctor and staff to provide any services deemed necessary. I authorize the use of this signature on all insurance submissions.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

________________________________ ________________
Patient Date

If you are signing as a personal representative of the patient, please indicate your relationship

__________________________ ____________________
Representative Relationship to Patient