NOTICE OF PRIVACY PRACTICES RECEIPT
CORNEA AND LASER EYE INSTITUTE

The Cornea and Laser Eye Institute keeps a record of the health care services we provide for you. You may ask to see and copy that record. We will not reveal your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting our Practice Manager.

Our **Notice of Privacy Practices** describes more in detail, how your health information may be used and revealed and how you can obtain your information.

You may refuse to sign this acknowledgement.

ACCOUNT NUMBER: _____

I, _____ acknowledge receiving the Cornea and Laser Eye Institute (CLEI) Notice of Privacy Practices. I also acknowledge that future revision of this notice will be available on upon request.

SIGNATURE _____

Date _____

CLEI Witness Name (Print) _____

CLEI Witness Signature _____

Date _____

For Office Use Only