



Master Eye Associates

HIPAA PRIVACY ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____ [Please print full legal name here] (the "Patient" or "Patient's legal representative"), have been presented with the Notice of Privacy Policy (the "Policy") of Master Eye Associates/ Dr. Brendon Lauer (the "Provider"), and have been offered a copy of such policy to keep for my records.

_____ [Please initial here] I hereby acknowledge that I have been provided with a copy of the Policy.

_____ [Please initial here] I hereby refuse to acknowledge receipt of the Policy. I understand that even though I may refuse to sign this acknowledgement, Provider may still provide treatment to me.

Signature of Patient /Guardian

Date

For Office Use Only

I, _____ [Please print full legal name here], acting as _____ [Please print relationship to or official position with Provider] for Provider attempted to obtain the written acknowledgment of receipt of the policy of provider on _____ [Please insert date attempt was made],

But acknowledgement could not be obtained because:

_____ [Please initial here] Patient or Patient's legal representative refused to sign.

_____ [Please initial here] Patient or Patient's legal representative could not be communicated with sufficient to obtain acknowledgement.

_____ [Please initial here] Emergency circumstances prevented securing acknowledgement.

_____ [Please initial here] Other (Please specify) _____

Signature of Provider representative

Date

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