

Coastal Eye Center, P.A.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

By my signature below, I acknowledge that a copy of Coastal Eye Center, P.A.'s

Notice of Privacy Practices is available to me.

Patient Name (Please Print)

E-MAIL: _____

Primary Care Physician: _____

X _____

Patient Signature

Date

Please list the names of any persons you wish information to be released to, if they call us.

Name & Relationship to Patient

Name & Relationship to Patient

Name & Relationship to Patient

***Emergency Contact-** Name & Relationship

Phone Number

Circle yes or no if messages can be left for patient with these forms of contact.

Home phone

Cell phone

Work phone

E-mail

Y / N

Y / N

Y / N

Y / N