CLEVELAND EYE CLINIC

World Class Excellence in Eyecare

ACKNOWLEDGEMENT OF NOTIFICATION

OF PATIENT'S RIGHTS TO PRIVACY

I acknowledge that I have been notified of Cleveland Eye Clinic's Notification of Patient's Rights to Privacy.

Patient Name: _____ Chart No: _____

Signature: _____ Date: _____

To allow Cleveland Eye Clinic to discuss your medical condition, treatment plan, surgery plan, appointment dates and times, etc. with a family member or other person involved in your health care, please list their names and their relationship to you below. You are not required to list anyone.

I authorize Cleveland Eye Clinic to release health information identifying me to the family members or other persons I have listed below:

Name_____ Relationship _____Phone_____

Name_____ Relationship _____Phone_____