PATIENT ACKNOWLEDGEMENT OF UNDERSTANDING OF PRIVACY PRACTICES

I, _____, hereby authorize the Eye Center of Central Georgia (ECCG), Medical Eye Associates (MEA), and Eye Designs (ED) to use my personal health information to provide health care, to handle billing and payments, and to take care of other health operations.

ECCG, MEA, and ED have a document called the "Notice of Privacy Practices," available for review at the office, as well as online at https://myeyecenter.com/contact-us/privacy-policy. It contains additional information about the policies and practices that protect a patient's privacy. I understand that I have the right to read this Notice before signing this Acknowledgement.

I also specifically authorize ECCG, MEA, and ED to discuss my personal health information with the following individuals:

NAME:	RELATIONSHIP:	PHONE NUMBER(S):	EXPIRATION OF AUTHORIZATION:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

_____ _____

PATIENT'S SIGNATURE (OR GUARDIAN'S SIGNATURE) DATE

_____ _____

Name of Legal Guardian (if applicable) Relationship to Patient

LAST REVISED JANUARY 1, 2021