KORNMEHL LASER EYE ASSOCIATES

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I _____ _____/_____/_____

(Patient Name) (Date of Birth)

acknowledge that I have received a copy of Kornmehl Laser Eye Associates' Notice of Privacy Practices. This Notice describes how Kornmehl Laser Eye Associates may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

_____

(Signature of Patient, or Personal Representative) (Date)

_____

(Relationship to Patient)