



**RECEIPT OF NOTICE OF PRIVACY PRACTICES**

**WRITTEN ACKNOWLEDGMENT FORM.**

I, \_\_\_\_\_,  
Patient Name

have received a copy of Laster Eye Center's Notice of  
Privacy Practices.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

I hereby authorize that the Laster Eye Center **has my permission to disclose** medical and  
financial information pertaining to my diagnosis and treatment to the following person(s):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_