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):

____

____

____

____

____

____