Braverman-Terry-Oei Eye Associates
The Ocular Surgery Center

Acknowledgement of Receipt of Notice of Privacy Practices

I certify that I have received a copy of Notice of Privacy Practices. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of Braverman-Terry-Oei Eye Associates/The Ocular Surgery Center health care operations. The Notice of Privacy Practices also describes my rights and Braverman-Terry-Oei Eye Associates/The Ocular Surgery Center duties with respect to my protected health information.

Braverman-Terry-Oei Eye Associates/The Ocular Surgery Center reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail, asking for one at the time of my next appointment.

_____
Signature of Patient or Personal Representative

_____
Name of Patient or Personal Representative

_____
Date

_____
Description of Personal Representative's Authority