GEORGIA VISION INSTITUTE GEORGIA CATARACT AND EYE SPECIALTY CENTER

PATIENT ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

Patient's Name		DOB
		act and Eye Specialty Center (GVI) to use ndle billing and payments, and to take care
	itional information abou	nilable for review at our office, as well as t the policies and practices that protect a is Notice before signing this
I also authorize GVI staff to discuss m results, billing/insurance information individual(s):		ation (appointment information, test g my general care) with the following
Name	Relationship	Phone Number
	-	
Patient or Guardian's Signature		Date
Name of Guardian or Personal Repre	sentative	Relationship to Patient