HIGH COUNTRY MACULA

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Notice of Privacy Practices Acknowledgment Receipt

By my signature below, I hereby acknowledge that I have received a Notice of Privacy Practices by High Country Macula, Retina, and Vitreous, PC.

Patient Name _____

Patient Signature _____ Date _____

For your privacy, will you grant us permission to call and/or leave messages at the phone number(s) you have provided us?

☐ No ☐ Yes

PLEASE DO NOT WRITE BELOW THIS LINE. FOR STAFF USE ONLY.

This acknowledgement page will be retained in patient's records. If acknowledgement could not be obtained from the patient, the reason(s) must be documented below.

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High Country Macula, Retina, and Vitreous, PC **highcountrymacula.com**

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