Notice of Privacy Practices

By signing this form, you acknowledge that you have been informed that ATLANTIC EYE CENTER provides information about how we may use and disclose your protected health information (PHI). We encourage you to read the "Notice of Privacy Practices" posted in our lobby. If you would like a paper copy, please ask the receptionist.

ATLANTIC EYE CENTER may use the following methods of communication regarding information related to my personal health, treatment or payment for treatment.
I acknowledge I am responsible for updating this information as necessary. This request supersedes any prior request for methods of communication I may have made.
Contact me by phone at:

Check Preferred Contact #

Home _____ ____

Work _____ ____

Cell _____ ____

[ ] ATLANTIC EYE CENTER may leave a message on my voice mail/answering machine
[ ] ATLANTIC EYE CENTER may speak to anyone who answers the phone

[ ] ATLANTIC EYE CENTER may only speak to
_____
[ ] ATLANTIC EYE CENTER may leave a message for me at my work phone number.

Questions or concerns about our Privacy Notice or Practices should be directed to the Privacy Officer at (609) 465-1616

Signature_____
Date_____ E-mail_____

Inability to obtain acknowledgement: *To be completed only if no signature is obtained:*

[ ]Patient lacks the ability to understand the Notice of Privacy Practices
Other_____

_____
Signature Of Office Representative