MASSACHUSETTS EYE AND EAR INFIRMARY, AND
MASSACHUSETTS EYE AND EAR ASSOCIATES, INC.

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

PATIENT NAME	
MEDICAL RECORD NUMBER	
DATE	

I acknowledge that I received, or have been offered and chose not to receive, the Massachusetts Eye and Ear Infirmary, and Massachusetts Eye and Ear Associates, Inc. Notice of Privacy Practices.

PATIENT SIGNATURE	

If patient is a minor or is otherwise unable to sign this Acknowledgment, the signature of a parent, guardian, or other legal representative is required:

PERSONAL REPRESENTATIVE NAME	
PERSONAL REPRESENTATIVE SIGNATURE	
RELATIONSHIP TO PATIENT	

For Internal Use Only:

The patient above received, or was offered and chose not to receive, the Notice of Privacy Practices, and declined to sign this Acknowledgment.

STAFF MEMBER NAME	
STAFF MEMBER SIGNATURE	