

## Acknowledgement of Receipt of Notice of Privacy Practices

Weaver Eye Associates  
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Dallastown, PA 17313

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Patient Name: \_\_\_\_\_

Patient SS# Number: \_\_\_\_\_ Patient Phone Number: \_\_\_\_\_

Patient Address: \_\_\_\_\_

***Signing this document signifies that you have  
received a copy of our Notice of Privacy Practices.***

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct healthcare operations involving our office. The ***Notice of Privacy Practices*** you have been given describes these uses and disclosures in detail.

**I acknowledge that I have received the *Notice of Privacy Practices* from Weaver Eye Associates.**

\_\_\_\_\_  
Signature Date

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form:

\_\_\_\_\_  
Relationship to Patient Print Name

Source of Authority: \_\_\_\_\_