



## Notice of Privacy Practices Written Acknowledgement Form

I, \_\_\_\_\_  
(Patient's printed name)

have been provided a copy of Andover Eye Associates' Notice of Privacy Practices and I have had the opportunity to read the Notice.

I authorize Andover Eye Associates to release my personal health information to the following individual(s):

*You may list as many individuals as you wish. Please print.*

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

I understand that I may change this list at any time.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date