NOTICE OF PRIVACY PRACTICES

Written Acknowledgement Form

I, ____
(Patient's Printed Name)

have been provided a copy of Carlsson Pediatric and Family Eye Center's Notice of Privacy Practices and I have had an opportunity to read the Notice.

I authorize Carlsson Pediatric and Family Eye Center to release my personal health information to the following individual(s) (Please Print). You may list as many individuals as you wish:

______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

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

______________________________	______________________________
Patient Signature or Legal Guardian (if minor)	Date