ACHIEVE
EYE & LASER SPECIALISTS

3260 NW Mount Vintage Way, Silverdale, WA 98383
Phone: 360 698 9500 Fax: 360 698 9900

Medical Record # _____

In accordance with our Notice of Privacy Practices, you have the right to exercise your Privacy Rights. A detailed copy of the Notice of Privacy Practices is available at the front desk, if you would like to review before signing, please see a receptionist.

PATIENT ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of the Notice of Privacy Practices effective October 2015.

_____	_____	_____	_____
Patient Signature (or Representative)	Relationship to Patient	Date	Time
_____		_____	_____
Witness		Date	Time

Do you give Achieve Eye & Laser Specialists permission to discuss your medical information about your care with any family members or close friends? ☐ YES ☐ NO

If yes, please provide names and contact information below if known:

☐ Name: _____ Relationship: _____ Phone: _____

☐ Name: _____ Relationship: _____ Phone: _____

☐ Name: _____ Relationship: _____ Phone: _____

In the event the patient or personal representative of the patient did not sign the acknowledgement, check (✓) one of the reasons below:

☐ Emergency Treatment Situation.

☐ Individual unable to sign because of medical condition and personal representative is not available.

☐ Individual refused. Reason: _____

☐ Other (explain): _____

_____	_____	_____
Witness Signature	Date	Time

Witness Name (print): _____