



OAKLAND EYE CARE

Ophthalmologist
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Optometrist
Ashley M. Wesley, O.D.

Notice of Privacy Practices and Acknowledgment

I, the undersigned, acknowledge that a copy of Notice of Privacy Practices is available to me.

X _____ Date _____
(Signature, Patient or Personal Representative)

If personal representative's signature appears above, please describe personal representative's relationship to the patient.

Please list the full name of any individual that we may speak to regarding your personal health information, such as a spouse, sons, daughters, or a significant other. Without this authorization, no information may be released to anyone other than yourself.

_____	Relationship _____
_____	Relationship _____
_____	Relationship _____
_____	Relationship _____
_____	Relationship _____
_____	Relationship _____

Please check the boxes that apply to you:

- You may leave health information on my answering machine.
- DO NOT leave health information on my answering machine.

- You may leave me a voice mail at work that includes health information.
- DO NOT leave me a voice mail at work that includes health information.

* To be filed and retained for a minimum of six (6) years
HIPPA form/acknowledgment/good faith efforts/06-08