OPTOMETRY CORNER

4940 Irvine Blvd. Ste 102
Irvine, CA 92620
(714) 730-9580

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Patient Name: _____ **D.O.B.** _____

Signing this document signifies that you have read and/or received a copy of this office's Notice of Privacy Practices.

In the course of providing eye care services 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 that you have been given describes these uses and disclosures in detail.

I acknowledge that I have read and/or received the Notice of Privacy Practices from Optometry Corner.

_____ _____
Signature Date

If signing as a legal representative of the patient, please describe relationship to the patient:

_____ _____
Relationship to Patient Print Name