Acknowledgement of Receipt of Notice of Privacy Practices

Franklin N. Smith, O.D.
4221 Mayfair Street
Myrtle Beach, SC 29577
Office: (843)-448-6630
Fax: (843)-448-5567

Patient Name: ______________________________

Phone Number: ____________________

Signing this document signifies that you have been informed of our Notice of Privacy Pracitices.

In the course of providing service 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.

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Signature Date

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form.

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Relationship to Patient Print Name

Source of Authority: ___________________________