Saddleback Eye Medical Associates, Inc.

Comprehensive Ophthalmology – Board Certified Eye Physicians & Surgeons

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I________________________ acknowledge that I have received a copy of Saddleback Eye Medical Associates, Inc.'s NOTICE OF PRIVACY PRACTICES. This notice describes how Saddleback Eye Medical Associates may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information and rights I may have regarding my protected health information.

____ ________________________

(Signature of Patient or Authorized representative) (Date)

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(Relationship to Patient)

TO WHOM IT MAY CONCERN:

I AUTHORIZE Saddleback Eye Medical Associates' Inc. to release information regarding my medical care or financial/insurance information to: ____ until revoked in writing by me, the undersigned.

(Spouse, legal guardian, family member)

Signed by: _____________________________________ Date:______________________________