WANDA PAK, M.D., P.C.

Ophthalmology, Ophthalmic Surgery, Laser Refractive Surgery

Privacy Practices

I have received a copy of the privacy policies of this practice entitled: "Privacy Practices"

Patient Name: _____ Date of Birth: _____

Signature:_____ Today's Date:_____

Please list individuals you grant our office permission to discuss the indicated aspects of your record:

Name: _____ Name: _____

Relationship: _____ Relationship: _____

___ medical information
___ appointments
___ financial account

___ medical information
___ appointments
___ financial account

Please indicate which aspects of your record we can leave on your voicemail:

____ medical information ____ appointments ____ financial account

Signature: _____ Today's Date:_____

<u>If Guarantor is other than patient:</u>

Print Name: _____ Signature: _____
Parent/Guardian

Witnessed:_____Date:_____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices, but was unable to do so as documented below:

Date:	Initials:	Reason: