Frantz EyeCare
Suncoast Surgery Center

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____ Date of Birth: _____

I hereby acknowledge that I have received and had an opportunity to ask questions concerning the above named practice's Notice of Privacy Practices.

_____ _____
PRINT: Patient Name Date

_____
Patient or Patient's Representative Signature

If signed by Representative, please state:

Name of Representative: _____

Relationship to Patient: _____