Offices of Wallerich Eye Care, LLC

Acknowledgement of Receipt of Notice of Privacy Practices

☐ **Wallerich Eye Care – St. Paul (Midway)**
1300 University Ave W
Saint Paul, MN 55104
T: (612) 643-3525
F: (612) 299-1452
Email: OM@WallerichEyeCare.com

☐ **Wallerich Eye Care – Eden Prairie**
8225 Flying Cloud Drive
Eden Prairie, MN 55344
T: (612) 643-3525
F: (612) 299-1452
Email: OM@WallerichEyeCare.com

This document is to be signed by a person legally responsible for the patient's medical decisions relative to the treatment situation. This document is also presented on the online form prior to receiving care at Wallerich Eye Care and serves as a receipt of notice (patient may also request a written copy at that point in time as well).

I,_____, hereby acknowledge that the office of Wallerich Eye Care, LLC has provided me with a copy of the Notice of Privacy Practices (upon request) that describes how medical information about me may be used and disclosed, and how I can access this information. I understand that if I have questions or complaints I may contact the offices of: Wallerich Eye Care, LLC (above addresses shown).

I also understand that I am entitled to receive updates upon request if the office amends or changes their Notice of Privacy Practices in a material way.

_____ _____

Patient Name (Print) _____

Date

Signature of Patient/if minor guardian

_____

Guardian Full Name/Relationship (Print)