MICHIGAN GLAUCOMA SPECIALISTS, P.C.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRATICES

By signing below, I acknowledge that I have been informed of the Privacy Practice Form of this office.

_______________________ Patient Signature

_______________________ Witness

_______________________ Date

Documentation of Failure to Obtain Signed Acknowledgement

On______________20__ ____________________presented this

Acknowledgement of Receipt of Privacy Practices Form to: -

____________________.The patient refused to provide a signature when requested.