You will need Acrobat 9.0 or later for this form to work probably. (FREE upgrade from www.adobe.com)
After completing form you may: 1) print form and bring it to us, 2) fax form to us.

CHELSEA *eye care*

205-678-2565

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I have reviewed or have been given the opportunity to receive a copy of Hartley E. Nichols, O.D.'s notice of Privacy Practices.

Patient Name _____
PLEASE PRINT

Patient/Guardian Signature _____Date_____
(Please Note: Guardian Signature is only acceptable if the patient is under the age of 14.)

If you are signing as a personal representative of the patient, please describe your relationship to the patient.

Print Name _____Relationship_____

If you would like to pre-authorize the release of your information to any persons that may handle your medical affairs, please list their name and relationship to you below.

Print Name _____Relationship_____

Print Name _____Relationship_____

Print Name _____Relationship_____