Office of Swoop Eye Care

Acknowledgment of Receipt of Notice of Privacy Practices

Swoop Eye Care
817 E 66th Street
Richfield, MN 55423

T: (612) 488-1566
F: (612) 488-1564
Email: Info@SwoopEye.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)