The ATLANTA VISION Institute

PF-2000 Acknowledgement of Receipt of Notice of Privacy Practices

The Atlanta Vision Institute reserves the right to modify the privacy practices outlined in the notice.

I have received a copy of the Notice of Privacy Practices for
The Atlanta Vision Institute

_____
Name of Patient (Print or Type)

_____
Signature of Patient

_____
Date

_____
Signature of Patient Representative
(Required if the patient is a minor or and adult who is unable to sign form)

_____
Relationship of Patient Representative to Patient

Please check box if you do not want your information use for fund raising purposes.

☐ Please do not use any information for fund raising purposes