EYE
LOVE
OPTICAL
Michael Stewart, O.D.

Today's Date___________

HIPPA ACKNOWLEDGEMENT RECEIPT

By initializing below, I acknowledge I was offered a copy of Michael Stewart, O.D.'s Notice of Privacy Practices.

______ Yes, I would like a copy of Michael Stewart, O.D.'s Notice of Privacy Practices.

______ No, I do not wish to receive a copy of Michael Stewart, O.D.'s Notice of Privacy Practices.

Due to HIPPA regulations, if you are over 18 years of age, please list any authorized person(s) with whom we can discuss your appointments, insurance, and/or payments with (i.e. spouse, parent, etc.)

Name of Authorized Person(s)	Relationship to Patient:
______________________________________	______________________________________
______________________________________	______________________________________
______________________________________	______________________________________