Pajka Eye Center Acknowledgment

of Receipt of Notice of Privacy Practices

I acknowledge that I have been provided Pajka Eye Center, Inc., Notice of Privacy Practices ("Notice"):

- It tells me how Pajka Eye Center, Inc., will use my Health Information for the purpose of my treatment, and Pajka Eye Center, Inc.'s healthcare operations.
- The Notice explains in more detail how Pajka Eye Center, Inc., may use and share my healthcare information for other than treatment, payment, and healthcare operations.
- Pajka Eye Center, Inc., will also use and share my health information as required/permitted by law.
- I authorize my healthcare provider and/or any entity authorized by my healthcare provider, including those using automated dialing systems, automated messages, email, text messaging and/or other electronic communication to contact me for any reason by using any telephone number, email address and/or mailing address associated with my account.

Patient's Complete Legal Name _____
(Please Print)

Patient's DOB _____ Date: _____

Signature: _____
(Patient or legal representative