Telephone List

Please provide name(s) of person(s) if any, to whom you would like LVCC to allow disclosures of personal information. Please also specify information that may be disclosed (i.e. test results, appointment information, payment information, patient's prescription, ordering of contact lenses and/or glasses, etc. You may also indicate "All" if appropriate.)

Name	Relationship/Contact Phone Number	Allowed Disclosure(s)
1.		
2.		
3.		
4.		
5.		
6.		
7.		

I ____, herby acknowledge that I have received a copy of Lifetime Vision and Contact Lens Center's Notice of Privacy Practices.

X ____ ____________________
Patient/Guardian Signature Date

X ____
Printed Name

----------------------------- **O F F I C E U S E O N L Y** ---------------------------

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

______________ __________ ____
Date Initials Reason