JOHN-KENYON
American EYE Institute

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# PRIVACY NOTICE ACKNOWLEDGEMENT OF RECEIPT

By signing this form, I acknowledge that I received the Privacy Notice and understand that my Protected Health Information may be used by the John-Kenyon American Eye Institute as described in the Notice.

I, __________________________, hereby authorize John-Kenyon American Eye Institute to release private medical information to or discuss my care with the following person(s):
**(Example: spouse, child, power-of-attorney, caretaker, family member)**

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Patient/Guardian Signature Date JKAEI Representative Date

E. Britt Brockman, M.D. | Maurice E. John, M.D. | Howard S. Lazarus, M.D. | Asim R. Piracha, M.D. | Timothy E. Schmitt, M.D. | Larry I. Alexander, O.D. | Randall L. Noblitt, O.D. | Steven M. Wilson, O.D.