JOHN-KENYON

Acknowledgement of Receipt

By signing this form, I acknowledge that I received the Notice of Privacy Practices 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)

_____ _____

_____ _____

_____ _____

_____ _____

Patient Signature Date Signature of Patient Representative (P.O.A., etc.) Date

_____ _____

John-Kenyon American Eye Institute Representative Date Relationship of Patient Representative to patient