FOLEY
EYE CLINIC

FORM 23005
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

_____

NAME OF INDIVIDUAL

This is to acknowledge receipt of a copy of **Foley Eye Clinic PA's** Notice of Privacy Practice with an effective date of ____/____/____ (mm/dd/yy).

Individual's (or Legal Representative's) Name:

_____

Individual's (or Legal Representative's) Signature:

_____

Date: _____

Capacity or Authority of Legal Representative (if applicable) *:

_____

*May be requested to provide verification of representative status.

_____

RECORDS TRANSFER FORM

I direct that all of my records be transferred from

_____

_____

_____

to Foley Eye Clinic, P.A.
1570 Concordia Avenue, Suite 201
St. Paul, MN 55104
651-287-2020 (Phone)
651-294-2020 (Fax)

Patient Signature: _____
Date: _____

2/15/12