ADVANCE EYELID SURGERY & LASER CENTER
Mayli Davis, M.D.

Acknowledgement of Receipt of Notice of Privacy Practices

I have been provided with this office's Notice of Privacy Practices to review, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____
Signature of Patient or Personal Representative

_____
Date

_____
Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority

This acknowledgement page should be retained in patient's record. If acknowledgement could not be obtained from patient, the reasons must be documented below.

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PLEASE TURN OVER AND SIGN THE THE CONSENT FORM TO BILL INSURANCE