LISA F. SKLAR, M.D.

RECEIPT OF NOTICE OF PRIVACY PRACTICES

WRITTEN ACKNOWLEDGMENT FORM

I, _____, have received a copy of Dr. Lisa Sklar's

Notice of Privacy Practices.

Please initial the spaces below to indicate your permission for our office to:

_____ Leave appointment reminders of your upcoming visits on your voicemail

_____ Leave test results (e.g., Visual Fields or blood test results) on your voicemail

_____ FAX pertinent exam results to your doctors or to doctors to whom we have referred you

Patient's Signature: _____

Date: _____