George J. Kaknis, OD
1073 Main Street
Suite 106
Fishkill, NY 12524
NPI# 1245215961

ACKNOWLEDGE OF RECIEPT & GENERAL CONSENT

I can pick up a full copy of the privacy practices of George J. Kaknis, OD. at my appointment. I further consent to the release of my health information for purposes of treatment, payment, and health care operations and as authorized or required by law under the circumstances described in the Notice of Privacy Practices.

Patient name:____

Patient must sign below. (If the patient is under 18 years of age their parent/guardian must sign below)

Signature:_________________________________**Date:**___________________

If you are signing as a personal representative or for a child under 18 years of age, describe your relationship to the patient and sign this form:

Relationship to patient:________________**Print name:**_________________________

Signature:_______________________________________

If you would like a family member/other party to be able to access your health information, please list that person(s)/parties name below and sign:

Name of other person(s)/parties:____

Relationship to Patient:__________________________________

Patient/Parent/Guardian Signature:____

I, (Print name)________________________, refuse to sign this consent.

Signature:_______________________________________**Date:**___________________