Acknowledgement of Receipt of
Notice of Privacy Practices

Patient Name: _____

Signing this document signifies that you have read and/or been offered a copy of our **Notice of Privacy Practices**.

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct healthcare operations involving our office. The Notice of Privacy Practices you have been given describes these uses and disclosures in detail.

I acknowledge that I have read and/or been offered the **Notice of Privacy Practices** from **All Eyes On You, Optometry**.

_____ _____

Signature **Date**

If signing as a personal representative of the patient, describe the relationship to the patient:

_____ _____

Relationship to patient **Date**

****For special designations***:

I, _____, give permission to specifically share my information with
print name

_____.
print name of designated person

_____
Signature

If you would like to take a copy of our *Notice of Privacy Practices* with you, please ask at the Front Desk.
You can also find out Notice of Privacy Practices on our website