Precision Vision Optometry

NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGEMENT OF RECEIPT

Date:_________________

The undersigned Patient or legally authorized representative of the Patient acknowledges that he or she received a copy of Precision Vision Optometry's Notice of Privacy Policies on the date indicated below. Copies are also located at the front desk.

Patient Name (Print): ____

Patient Signature: ____

If completed by a patient's legally authorized representative, please print and sign your name in the space below (attach appropriate documentation):

__________________________________ __________________________________

Legally Authorized Representative (Print) Legally Authorized Representative's Signature

This form should be placed in the patient's medical record