HIPAA Notice of Privacy Practices - Acknowledgement Of Receipt

I am a patient of EyeCheck Optometry.

I hereby acknowledge that I received a copy of EyeCheck Optometry Notice of Privacy Practices.

Name [Please Print] : ____

Sign:____

Date:_______________________

OR

I am a parent or legal guardian of ______________________________________.
I hereby acknowledge that I received a copy of EyeCheck Optometry Notice of Privacy Practices with respect to the patient.

Name [Please Print]: ____

Relationship to Patient: [ ] Parent [ ] Legal Guardian [ ] Other
____

Sign: _______________________

Date: _______________________

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