ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Balfour Vision Optix Optometry
3840 Balfour Road, Suite A
Brentwood, CA 94513
(925)513-0323

Family Optometric Vision Care
5109 Lone Tree Way
Antioch, CA 94531
(925)757-5560 or (925)778-1505

Patient Name: ____

Date of Birth: ______________________________

Signing this document signifies that you have received 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 received the *Notice of Privacy Practices* from Vision Optix Optometry.

____ ____________________

Signature (Patient, Parent, Guardian) Date

If signing as a personal representative of the patient, please print your name and describe the relationship to the patient.

____ ____________________

Print Name Relation to Patient