Acknowledgment of Receipt of Notice of Privacy Practices
Visual Eyes
Dr. K. Wrigley – Dr. J. Jones
1924 County Line Road
Huntingdon Valley, PA 19006
215-357-9011

Patient Name_____ (please print)

Address_____

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 Visual Eyes

Signature_____ **Date**_____
If signing as a personal representative of the patient, describe the relationship to the patient and source of authority to sign this form.

_____ _____
Relationship to Patient **Print Name**