Acknowledgement of Receipt

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 Lifetime Vision Care, LLC.

_____ _____

Signature *Date*

_____

Printed name as written above

If signing as a personal representative, describe relationship to the patient and the source of authority to sign this form:

_____

Rev 09/13