ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I have been offered a copy of the
Notice of Privacy Practices from the office(s) of:

CLEMENTS
VISION CARE

Clements Vision Care LLC
1455 W Main St,
2808 Prairie Lakes Dr Ste 106
Sun Prairie, WI 53590

Jeffrey S. Clements, O.D.
Lisa S. Zarwell, O.D.
Jessamyn M. Kovacs, O.D.

Print Patient Name _____

Signature _____
(If under the age of 18, please have parent/guardian sign.)

Date _____

I give permission for the following person(s) to have access to my vision records from Clements Vision Care LLC:

1) _____

2) _____

3) _____