ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I have been offered a copy of the
Notice of Privacy Practices from the office of:
Wright Vision Care LLC; 1455 W Main St, Sun Prairie, WI 53590
Richard T. Wright, O.D.
Frederic T. Gordon, O.D.
Lisa S. Zarwell, O.D.
Jeffrey S.Clements, O.D.

Print Patient name ____

Signature ____

(If under age 18, please have parent/guardian sign.)

Date ___________________________

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

1) ____

2) ____

3) ____