ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I have been offered a copy of the
Notice of Privacy Practices from the office(s) of:
Wright Vision Care LLC
1455 W Main St,
2808 Prairie Lakes Dr, Ste 106
Sun Prairie, WI 53590

Richard T. Wright, O.D.
Frederic T. Gordon, O.D.
Lisa S. Zarwell, O.D.
Jeffrey S. Clements, O.D.
Jessamyn M. Kovacs, 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) ____