

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.
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) _____