LaPOINT EYE CLINIC

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ACKNOWLEDGEMENT OF RECEIPT
NOTICE OF PRIVACY PRACTICES

We are legally required to give you this Notice and to get a signed statement that you received it. By signing this form, you are saying that you have received LaPoint Eye Clinic's **Notice of Privacy Practices.**

LaPoint Eye Clinic's **Notice of Privacy Practices tells you how we can use and disclose your health information. It also describes certain rights you have about your health information kept by us. Please review the Notice of Privacy Practices carefully.**

The undersigned hereby acknowledges receipt of Notice of Privacy Practices for LaPoint Eye Clinic **and each of its locations and components.**

Patient's Printed Name	Medical Record Number
Patient Signature	Date
Parent/Guardian Signature	Relationship to Patient

If the patient did not sign an acknowledgement of receipt of the Notice of Privacy Practices, complete the following:

List efforts taken to get patient's acknowledgement and reasons acknowledgement was not signed:

Signature of Staff Member	Location
Printed Name of Staff Member	Date