ACKNOWLEDGMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

Patient Name: _____
Medical Record No. _____
Office Name: Stoughton Eye Care & Eyewear, LLC

I have been given a copy of the Office's Notice of Privacy Practices ("Notice"), which describes how my health information is used and shared. I understand that the Office has the right to change this Notice at any time. I may obtain a current copy by contacting the Office Privacy Official, or by visiting the Office web site at www.stoughtoneyecare.com.

My signature below acknowledges that I have been provided with a copy of the Notice of Privacy Practices:

_____ _____
Signature of Patient or Personal Representative Date

_____
Print Name

_____
Personal Representative's Title (e.g., Guardian, Executor of Estate, Etc.)

For Office Use Only: Complete this section if you are unable to obtain a signature.

1. If the patient or personal representative is unable or unwilling to sign this Acknowledgment, or the Acknowledgment is not signed for any other reason, state the reason:

_____
_____

2. Describe the steps taken to obtain the patient's (or personal representatives) signature on the Acknowledgment:

_____
_____

Completed by:

_____ _____
Signature of Office Representative Date

_____
Print Name