Pacific Vision Medical Center

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Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I have received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices upon request or at my next scheduled appointment.

Signed: _____

Print Name: _____ Date: _____

If not signed by the patient, please indicate relationship:
~ parent or guardian of minor patient
I guardian or conservator of an incompetent patient

For *Office Use Only:* *Account No:*

Complete the following only if the patient refuses to sign the acknowledgement:

Date: ___ ___ Initials: _____

Patient refused to sign and refused to take information.
Patient took information, but refused to sign
Other (specify reason for refusal) _____