Acknowledgment of Receipt of Notice of Privacy Practices

Hillcrest Optometry
1246 University Avenue
San Diego, CA, 92103
Phone: (619) 291-0202
Fax: (619) 291-3807

Patient Name: _____
Patient Phone Number: _____
Patient Address: _____

Signing this document signifies that you have received a copy of our Notice of Privacy Practices.

In the course of providing service to you, we create, receive, and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct healthcare operations involving our office. The **Notice of Privacy Practices** you have been given describes these uses and disclosures in detail.

I acknowledge that I have received the Notice of Privacy Practices from Hillcrest Optometry.

_____ _____/_____/_____
Signature Date

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form:

_____ _____
Relationship to Patient Print Name