ACKNOWLEDGEMENT OF RECEIPT
NOTICE OF PRIVACY PRACTICES

Stamper Optometry Inc.
2508 Mission Street
San Francisco, CA 94110
415-824-2374
415-282-4781 fax

Patient name: ____

Address: ____________________________ Phone #: ______________

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 the 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 *Stamper Optometry Inc.*

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: ____

Source of Authority: ______________________________________