MANKATO VISION CENTER

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I _____

(Name of Patient)

acknowledge that I have received a copy of Mankato Vision Center's Notice of Privacy Practices. This notice describes how Mankato Vision Center may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and I may have regarding my protected health information.

_____

Signature of patient or Personal Representative Date

_____

Relationship to Patient

By signing this acknowledgement, I'm also agreeing to Mankato Vision Center's policies regarding contact lens care, prescription expiration dates, office visits, billing, etc. I understand that I may request a copy of said document at any time.