Virginia Pediatric Eye Center

Acknowledgment of Receipt of Notice of Privacy Practices

Patient Name_____ Date of Birth_____

By signing this form, you acknowledge that you have received our "Notice of Privacy Practices" (the "Notice").

Our Notice describes in detail how we might use or disclose your protected health information. The Notice also discusses your rights and our duties with respect to your protected health information. You have the right to review the Notice before signing this acknowledgement.

I acknowledge that I have received a copy of Virginia Pediatric Eye Center's Notice of Privacy Practices.

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Signature of Patient/Parent/Guardian/Authorized Representative Date