

# Vision Plus

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## HIPAA COMPLIANCE ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of the notice of Privacy Practices for  
Vision Plus on \_\_\_\_\_, 20\_\_\_\_\_.

Patient Name \_\_\_\_\_

Patient Signature \_\_\_\_\_

Emergency contact(s) who may also be notified of any medical information on your behalf:

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone # \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone # \_\_\_\_\_