

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I have received a copy of Dutchess Optometry's Notice of Privacy Practices.

Patient's name _____

Signature _____ Date _____

I authorize that my health care information can be shared with:

Print name: _____ Relationship: _____

Print name: _____ Relationship: _____

Print name: _____ Relationship: _____

Signature _____ Date _____