

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
California Eye Clinic

**3747 Sunset Lane
Antioch, CA 94509
(925) 754-2300**

**1181 Central Blvd., Suite F
Brentwood, CA 94513
(925) 516-0888**

**2260 Gladstone Drive, Suite 3
Pittsburg, CA 94565
(925) 427-2111**

**301 Lennon Lane, Suite 201
Walnut Creek, CA 94598
(925) 932-1123**

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices.

Signed: _____ Date: _____

PrintName: _____ Telephone: _____

if not signed by the patient, please indicate:

Relationship::

- parent or guardian of minor patient
 guardian or conservator of an incompetent patient
 beneficiary or personal representative of deceased patient

Name of Patient: _____

NOTICE OF PRIVACY PRACTICES (Acknowledgements Tracking Information)

Name of Patient: _____

Address: _____

complete the following only if the Patient refuses to sign the Acknowledgement:

Efforts to obtain: _____

Reasons for refusal: _____
