

Crystal Vision Center

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

I acknowledge that I was given a copy of the Notice of Privacy Practices, and that I have read (or had the opportunity to read if I so choose) and understood the Notice.

Patient Name (please print)

Date

Parent or Authorized Representative (if applicable)

Signature

Please feel free to ask for a printed copy of our Privacy Practice Notice.

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