FAMILY Vision CARE
OF MILFORD

ACKNOWLEDGEMENT OF READING OR RECEIPT

Signing this means you acknowledge our commitment to be in compliance with Federal regulations that require all Health Care Providers to make every possible effort to keep your personal health care information confidential.

Though you may decline to sign, we are required to present this notice to you for your signature.

Thank you

I acknowledge that I have been given an opportunity to read, and offered a copy of Philip S. Aubrey, O.D.'s **"NOTICE OF PRIVACY PRACTICES"**.

Patient name _____

Signature _____ Date_____

Do not write below this line

Offered_____ Date_____