CENTRAL KENTUCKY EYECARE
HIPPA COMPLIANCE ACKNOWLEDGEMENT OF RECEIEPT

-I acknowledge that I have been offered a copy of Central Kentucky Eyecare's Notice of Privacy Practices.

-I acknowledge that I have the right to request a mailed or electronic copy of Central Kentucky Eyecare's Notice of Privacy Practices at any time after my appointment.

Date:________________

Name:____
(Patient Name Printed)

Signature:____
(Patient/Parent if Minor/Guardian)