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**HIPAA COMPLIANCE ACKNOWLEDGEMENT OF RECEIPT**

I acknowledge that I have read/received a copy of Francis Eye Center, LLC's **NOTICE OF PRIVACY PRACTICES**.

Printed Patient Name: \_\_\_\_\_

Patient Birth Date: \_\_\_\_\_

\_\_\_\_\_  
Signature of patient or patient's representative/parent

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of patient's representative/parent

\_\_\_\_\_  
Relationship to patient