

# Acknowledgement of Receipt of Notice of Privacy Practices

Vision Surgery and Associated Eye Surgical Center  
Drs. Ochsner & Kingrey  
1100 N. Topeka, Wichita, KS 67214  
(316) 263-6273  
(316) 263-5568 Fax

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

Patient Number: \_\_\_\_\_ Patient Phone Number: \_\_\_\_\_

Patient Address: \_\_\_\_\_

***Signing this document signifies that you have  
received a copy of our Notice of Privacy Practices.***

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct healthcare operations involving our office. The **Notice of Privacy Practices** you have been given describes these uses and disclosures in detail.

**I acknowledge that I have received the *Notice of Privacy Practices* from (Vision Surgery and Associated Eye Surgical Center.)**

\_\_\_\_\_  
Signature Date

If signing this as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form:

\_\_\_\_\_  
Relationship to Patient Print Name

Source of Authority: \_\_\_\_\_

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
  - Communications barriers prohibited obtaining the acknowledgement
  - An emergency situation prevented us from obtaining acknowledgement
  - Other (Please Specify) \_\_\_\_\_
- \_\_\_\_\_