



**ACKNOWLEDGEMENT OF RECEIPT
OF
AECC'S PRIVACY PRACTICES**

I acknowledge that I received a copy of Alaska Eye Care Centers, APC.'s **Notice of Privacy Practices**. *Note: if patient is a minor, parent or legal guardian must sign.*

Date: _____

Patient's Printed Name: _____

Patient's Signature (18 years and older): _____

If patient is a MINOR, parent or legal guardian must sign.

Printed Name of **Parent or Legal Guardian**: _____

Signature of **Parent or Legal Guardian**: _____

Witness: AECC Representative

Date: _____

AECC Representative's Printed Name: _____

AECC Representative Signature: _____

Original to chart & scan into patient E-chart