**Michael P. Wood, O.D.**
**1760 Woodruff Road, Greenville, S.C. 29607**
**(864) 458-9600**

# Acknowledgement of Reading and Receipt, if requested, of Notice of Privacy Practices

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Patient Name: ______________________________________________

Patient Insurance: ___________________________________________

***Signing this document signifies that you have read and understand our Notice of Privacy Practices. A copy of the privacy practices can be given to you upon request.***

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 with other physicians, insurances, etc. in order to treat you with the utmost in quality care, to obtain payment for our services, and to conduct healthcare operations involving our office. The ***Notice of Privacy Practices*** you have read describes these uses and disclosures in detail.

**I acknowledge that I have read the *Notice of Privacy Practices* from Vision PLUS.**

______________________________________ ____________________
Patient Signature (18 or Older) Date

If signing as a personal representative of the patient, describe the relationship to the patient.

____________________________ ____________________________
Relationship to Patient Print Name