Trang Nguyen, O.D.,F.A.A.O.

2901 Wilshire Blvd, Suite 100, Santa Monica, CA 90403
(310) 449-0066 Fax (310) 453-2971

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name:_____

Patient Phone Number:_____

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 health care operations involving our office. The *Notice of Privacy Practices* you have been given describes uses and disclosures in detail.

I acknowledge that I have received the *Notice of Privacy Practices* from Trang Nguyen, O.D.,F.A.A.O.,

_____ _____
Signature Date

If signing 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