Acknowledgement of Receipt

Notice of Privacy Practices

Dr. Christopher Sween Optometrist Inc.

4589 Kapolei Pkwy.

Kapolei, Hi 96707

(808) 674-3913 (office)

(808) 674-3914 (fax)

Patient Name:____

Patient Number:____________________ Patient Phone Number:____________________

Patient Address:____

Signing this document signifies that you have received/read and understand

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/read describes these uses and disclosures in detail.

I acknowledge that I have received/read the *Notice of Privacy Practices* from Dr. Chris Sween.

____ ____________________

Signature Date