

## NOTICE RECEIPT ACKNOWLEDGMENT

---

Purpose: This form is used to confirm that an individual has received **Colorado Ophthalmology Associates, P.C.**

Notice of Privacy Practices.

---

I, \_\_\_\_\_, acknowledge that I have received **Colorado Ophthalmology Associates, P.C.** Notice of Privacy Practices. I have had full opportunity to read and consider the contents of this Notice of Privacy Practices.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

If this authorization is signed by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name: \_\_\_\_\_

Relationship to Individual: \_\_\_\_\_