

F3.2B

Practice: VISION QUEST EYE CLINICS
Address: 2294 WEST LINCOLN HWY, MERRILLVILLE, IN 46410
Privacy Official: ANGIE DOWNING
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Notice of Privacy Practices Receipt

I acknowledge that I was provided with the Notice of Privacy Practices of the Medical Practice named at the top of this page.

Print Name of Patient:	_____
Signature of Patient:	_____
Date:	_____
Patient's Date of Birth:	_____
Patient's ID/Chart Number:	_____

For Personal Representative of the Patient (if applicable)

Print Name of Personal Representative:	_____
Describe Personal Representative Relationship (parent, guardian, etc):	_____
Signature of Personal Representative:	_____
Date:	_____

For Practice Use Only:

Signature of Practice Employee

Date