

**EYE CLINIC OF SANDPOINT  
307 S 1<sup>st</sup> AVENUE  
SANDPOINT ID 83864**

**ACKNOWLEDGEMENT OF RECEIPT  
OF NOTICE OF PRIVACY PRACTICES**

By signature below, I acknowledge that I have received EYE CLINIC OF SANDPOINT'S Notice of Privacy Practices.

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Name

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Signature

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Date

*This acknowledgement page should be retained in patient's record.  
If acknowledgement could not be obtained from patient,  
the reason must be documented below.*

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