Acknowledgment of Receipt of Notice of Privacy Practices

I,	
acknowledge that I have received a copy of Sierra F	Eye Associates' Notice of
Privacy Practices. This notice describes how Sierra	Eye Associates may use
and disclose my protected health information, certa	in restrictions on the use
and disclosure of my healthcare information, and ri	ghts I may have
regarding my protected health information.	
Signature of Patient, or Personal Representative	Date
Relationship to Patient	