



Midland Eye Care

Drs. Johnson & Associates

A MEMBER OF *VISION SOURCE*

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The undersigned Patient, or legally authorized representative (“Agent”) of the Patient, acknowledges that he or she personally received a copy of the Midland Eye Care Notice of Privacy Practices on the date indicated below.

Signature: _____ Date: _____

Patient: _____