Tri-State Centers for Sight inc.

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

1. By signing below, I acknowledge that I have been given the opportunity to read and receive a copy of Tri-State Centers For Sight, Inc.'s Notice of Privacy Practices ("Notice").

Date: _____

Signature (Patient or Authorized Representative) _____

Printed (Patient or Authorized Representative) _____

FOR OFFICE USE:

If you are unsuccessful in obtaining a signature from the patient or authorized representive explain circumstances below.

_____

_____

_____

Signature Staff Member _____

Date: _____