NOTICE OF PRIVACY PRACTICES

Frontier Vision Clinic, P.C.

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307-635-1073
Fax: 307-635-1078
Contact: Dr. Brett Pexton, O.D.
Expires 3 years from Signature Date

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Frontier Vision Clinic's Notice of Privacy Practices.

Patient Name (Print): ____

Signature: ______________________________________ Date: ________________

Parent/Responsible Name (Print): ______________________________________

Parent/Responsible Party Signature: ______________________ Date: ________________

I also ask that my records, health information and personal information be shared with the following people per their or my request:

	Name	DOB	Relationship
1.			
2.			
3.			
4.			