Kieth J. Burkart O.D., A Professional Corporation

ACKNOWLEDGEMENT OF RECEIPT 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 Kieth J. Burkart, O.D., A Professional Corporation's Notice of Privacy Policies on the date indicated below.

***Patient Name (Printed)*____**

***Patient/Legal Representative Signature*____________________________________**

***Date:*____**

Information about Legal Representative or Agent:

***Legal Representative/Agent Name (Printed)*_________________________________**

***Title*____**