ACKNOWLEDGEMENT
OF
NOTICE OF PRIVACY PRACTICES

The law requires that Vision Health Center, Inc. make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

- ☐ *I have read or had explained* to me Vision Health Center, Inc.'s Notice of Privacy Practice and agree to continue my care with Vision Health Center, Inc. under said terms.
- ☐ *I was given the opportunity* to read Vision Health Center, Inc.'s Notice of Privacy Practices and declined but wish to continue my care with Vision Health Center, Inc. under the terms of Vision Health Center, Inc.'s privacy policies.
- ☐ *I have read or had explained* to me Vision Health Center, Inc.'s Notice of Privacy Practice and do not wish to continue my care with Vision Health Center, Inc. under said terms.
- ☐ The Notice of Privacy Practice could not be read due to the emergent nature of the care of other reason described as

  _____
  _____

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

_____ _____
Patient Date

If you are signing as a personal representative of the patient, please indicate your relationship

_____ _____
Representative Relationship to Patient