ACKNOWLEDGEMENT
OF
NOTICE OF PRIVACY PRACTICES

The law requires that Advanced Eyecare make every effort to inform you of your rights related to your personal health information.

Please **choose one (1)** of the following options. By signing below, I acknowledge that:

- ☐ I have read or had explained to me Advanced Eyecare's Notice of Privacy Practices and agree to continue my care with Advanced Eyecare under said terms.

- ☐ I have read or had explained to me Advanced Eyecare's Notice of Privacy Practices and do not wish to continue my care with Advanced Eyecare under said terms.

- ☐ The Notice of Privacy Practices 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 below.

_____ _____

Representative Relationship to Patient