**ACKNOWLEDGEMENT**

**OF**

**NOTICE OF PRIVACY PRACTICES**

The law requires that Today’s Vision Bulverde make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

PLEASE CHECK ONLY ONE.

* I have read or had explained to me Today’s Vision Bulverde’s Notice of Privacy Practice and agree to continue my care with Today’s Vision Bulverde under said terms.
* I was given to opportunity to read Today’s Vision Bulverde’s Notice of Privacy Practices and declined but wish to continue my care with Today’s Vision Bulverde under the terms of Today’s Vision Bulverde’s privacy policies.
* I have read or had explained to me Today’s Vision Bulverde’s Notice of Privacy Practice and do not wish to continue my care with Today’s Vision Bulverde 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

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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

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Representative Relationship to Patient