ACKNOWLEDGEMENT
OF
NOTICE OF PRIVACY PRACTICES

The law requires that First Eye Care 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 First Eye Care's Notice of Privacy Practice and agree to continue my care with First Eye Care under said terms.
- ☐ I was given the opportunity to read First Eye Care's Notice of Privacy Practices and declined but wish to continue my care with First Eye Care under the terms of First Eye Care's privacy policies.
- ☐ I have read or had explained to me First Eye Care's Notice of Privacy Practice and do not wish to continue my care with First Eye Care 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

  _____
  _____

Please list the names of persons with whom you authorize First Eye Care to communicate regarding your medical care and financial records. If no names are listed, First Eye Care is not authorized to release any information of any kind to family or friends on your behalf.

_____ _____
Name Relationship

_____ _____
Name Relationship

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

_____ ___/___/_____ _____
Patient DOB Date

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

_____ _____
Representative Relationship to Patient