ACKNOWLEDGEMENT
OF
NOTICE OF PRIVACY PRACTICES

The law requires that La Pine Eyecare Clinic make every effort to inform you of your rights related to your personal health information. These rights are explained in La Pine Eyecare Clinic's Notice of Privacy Practices. By signing below, I acknowledge that:

- ☐ I have read, been given the opportunity to read but declined, or had La Pine Eyecare Clinic's Notice of Privacy Practices explained to me and agree to continue my care with La Pine Eyecare Clinic under said terms.

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

- ☐ The Notice of Privacy Practice could not be read due to the emergent nature of the care or other reason described below:

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

______________________________ ______________

Patient Signature **Date**

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Printed Name

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

______________________ ______________________

Representative Signature Printed Name

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Relationship to Patient (parent, spouse, POA)