## ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

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

  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