ACKNOWLEDGEMENT
OF
NOTICE OF PRIVACY PRACTICES

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

  _____
  _____

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

_____ _____
Representative Relationship to Patient