ACKNOWLEDGEMENT
OF
NOTICE OF PRIVACY PRACTICES

The law requires that Cleburne & Family Eye Clinics make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

Choose only one choice:

- ☐ I have read or had explained to me Cleburne & Family Eye Clinics' Notice of Privacy Practices and agree to continue my care with Cleburne & Family Eye Clinics under said terms.
- ☐ I was given to opportunity to read Cleburne & Family Eye Clinics' Notice of Privacy Practices and declined but wish to continue my care with Cleburne & Family Eye Clinics under the terms of Cleburne & Family Eye Clinics' privacy policies.
- ☐ I have read or had explained to me Cleburne & Family Eye Clinics' Notice of Privacy Practice and **DO NOT** wish to continue my care with Cleburne & Family Eye Clinics 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 to the patient.

_____ _____
Representative Relationship to Patient