ACKNOWLEDGEMENT OF

NOTICE OF PRIVACY PRACTICES

The law requires that Eyeworks make every effort to inform you of your rights related to your personal health information. By signing below, I acknowledge that:

(check only one)

_____ I have read, or had explained to me, Eyeworks' Notice of Privacy Practices and agree to continue my care with Eyeworks under said terms.

_____ I was given the opportunity to read Eyeworks' Notice of Privacy Practices and declined but wish to continue my care with Eyeworks under the terms of Eyeworks' privacy policies.

_____ I have read or had explained to me Eyeworks' Notice of Privacy Practices and do not wish to continue my care with Eyeworks under said terms.

_____ The Eyeworks' Notice of Privacy Practices could not be read due to the emergent nature of the care or other reason as described below:

____

____

____

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________________________