ACKNOWLEDGEMENT
OF
NOTICE OF PRIVACY PRACTICES

The law requires that Family Vision Solutions make every effort to inform you of your rights related to your personal health information. By my checking **one box** and signing below, I acknowledge that:

☐ Yes, I have read or had explained to me Family Vision Solutions' Notice of Privacy Practice and agree to continue my care with Family Vision Solutions under said terms.

or

☐ Yes, I was given to opportunity to read Family Vision Solutions' Notice of Privacy Practices and declined to read it, but wish to continue my care with Family Vision Solutions under the terms of Family Vision Solutions' privacy policies.

or

☐ No, I have read or had explained to me Family Vision Solutions' Notice of Privacy Practice but do not wish to continue my care with Family Vision Solutions under said terms.

or

☐ No, 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