**ACKNOWLEDGEMENT**

**OF**

**NOTICE OF PRIVACY PRACTICES**

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

**\*\*Please check only ONE box below\*\***

* I have read or had explained to me Blink Vision Center’s Notice of Privacy Practice and agree to continue my care with Blink Vision Center under said terms.
* I was given the opportunity to read Blink Vision Center’s Notice of Privacy Practices and declined but wish to continue my care with Blink Vision Center under the terms of Blink Vision Center’s privacy policies.
* I have read or had explained to me Blink Vision Center’s Notice of Privacy Practice and do not wish to continue my care with Blink Vision Center 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

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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

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Representative Relationship to Patient