ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

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