

**ACKNOWLEDGEMENT
OF
NOTICE OF PRIVACY PRACTICES**

The law requires that Killeen Eyecare Center 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 Killeen Eyecare Center's Notice of Privacy Practice and agree to continue my care with Killeen EyeCare Center under said terms.

- I was given the opportunity to read Killeen Eyecare Center's Notice of Privacy Practices and declined but wish to continue my care with Killeen Eyecare Center under the terms of Killeen Eyecare Center's privacy policies

- The Notice of Privacy Practice could not be read due to the emergent nature of the care or 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