

**ACKNOWLEDGEMENT
OF
NOTICE OF PRIVACY PRACTICES**

The law requires that Sloan Optometry make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that (Please pick one):

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