ACKNOWLEDGEMENT
OF
NOTICE OF PRIVACY PRACTICES

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