Patient name: _____

ACKNOWLEDGEMENT

OF

NOTICE OF PRIVACY PRACTICES

The law requires that Newberg Vision Clinic, PC 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 Newberg Vision Clinic, PC's Notice of Privacy Practice and agree to continue my care with Newberg Vision Clinic, PC under said terms.

____ I was given the opportunity to read Newberg Vision Clinic, PC's Notice of Privacy Practices and declined but wish to continue my care with Newberg Vision Clinic, PC under the terms of Newberg Vision Clinic, PC's privacy policies.

____ I have read or had explained to me Newberg Vision Clinic, PC's Notice of Privacy Practice and do not wish to continue my care with Newberg Vision Clinic, PC under said terms.

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

_____ _____

Representative **Relationship to Patient**