ACKNOWLEDGEMET
OF
NOTICE OF PRIVACY PRACTICES

The law requires that Salem 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 Salem Eye Clinic's Notice of Privacy Practice and agree to continue my care with Salem Eye Clinic under said terms.**

_____ I was given to opportunity to read Salem Eye Clinic's Notice of Privacy Practices and declined but wish to continue my care with Salem Eye Clinic under the terms of Salem Eye Clinic's privacy policies.

_____ I have read or had explained to me Salem Eye Clinic's Notice of Privacy Practice and do not wish to continue my care with Salem 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 below

Please list First and Last Name of any Person with authorization to access your medical and/or billing information

Relation to Patient

_____

Relation to Patient

_____

Relation to Patient

_____