ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

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

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

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

◯ 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**

VALLEY VISION CLINIC LTD.

EXCELLENCE. EXPERIENCE. COMPLETE CARE!