ACKNOWLEDGEMENT
OF
NOTICE OF PRIVACY PRACTICES

The law requires that Fornara Eye Center, PC make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

SELECT ONE

- ☐ I have read or had explained to me prior to any services offered Fornara Eye Center's Notice of Privacy Practices and agree to continue my care with Fornara Eye Center under said terms.
- ☐ I was given the opportunity to read Fornara Eye Center's Notice of Privacy Practices and declined but wish to continue my care with Fornara Eye Center under the terms of Fornara Eye Center's privacy policies.
- ☐ I have read or had explained to me prior to any services offered Fornara Eye Center's Notice of Privacy Practices and do not wish to continue my care with Fornara Eye Center under said terms.
- ☐ The Notice of Privacy Practices could not be read due to the emergent nature of the care or other reason as described below.

_____
_____

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

_____ _____
Patient name (please print) Date of Birth

_____ _____
Patient Signature Date

If you are signing as a personal representative of the patient, please indicate your relationship

_____ _____
Representative (please print) Relationship to Patient

_____ _____
Representative Signature Date