ACKNOWLEDGEMENT OF
NOTICE OF PRIVACY PRACTICES

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

OR

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

OR

- ☐ I have read or had explained to me Downey Eye Clinic's Notice of Privacy Practice and **do not wish to continue my care** with Downey Eye Clinic under said terms.

OR

- ☐ The Notice of Privacy Practice **could not be read** due to the emergent nature of the care of other reason described as

  _____

  _____

ALSO

- ☐ I agree to allow communication with Downey Eye Clinic through standard email systems although it is my understanding that this mode of communication is not considered safe.

  Email: _____

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 Date