



ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES (ANPP)

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

**** CHECK ONE ****

- I have read or had explained to me Visualeyes Optometry's Notice of Privacy Practice and agree to continue my care with Visualeyes Optometry under said terms.
- I was given the opportunity to read Visualeyes Optometry's Notice of Privacy Practices and declined but wish to continue my care with Visualeyes Optometry under the terms of Visualeyes Optometry's privacy policies.
- I have read or had explained to me Visualeyes Optometry's Notice of Privacy Practice and do not wish to continue my care with Visualeyes Optometry 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

Representative

Relationship to Patient