ACKNOWLEDGEMENT
OF
NOTICE OF PRIVACY PRACTICES

The law requires that The Eye Institute of Wyoming, P.C. 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 The Eye Institute of Wyoming, P.C.'s Notice of Privacy Practice and agree to continue my care with The Eye Institute of Wyoming, P.C. under said terms.

- ☐ I was given the opportunity to read The Eye Institute of Wyoming, P.C.'s Notice of Privacy Practices and declined but wish to continue my care with The Eye Institute of Wyoming, P.C. under the terms of The Eye Institute of Wyoming, P.C.'s privacy policies.

- ☐ I have read or had explained to me The Eye Institute of Wyoming, P.C.'s Notice of Privacy Practice and do not wish to continue my care with The Eye Institute of Wyoming, P.C. 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

I agree that The Eye Institute of Wyoming, P.C. may disclose certain information of my healthcare to a Personal Representative of my choosing since such person is involved with my healthcare or payments. In that case, The Eye Institute of Wyoming, P.C. will disclose only information that is directly relevant to the person's involvement with my healthcare or payments.

Name _____ Phone _____

Name _____ Phone _____

Name _____ Phone _____