

**ACKNOWLEDGEMENT  
OF  
NOTICE OF PRIVACY PRACTICES**

The law requires that Tomball 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 Tomball Vision Clinic's Notice of Privacy Practice and agree to continue my care with Tomball Vision Clinic under said terms.
- I was given an opportunity to read Tomball Vision Clinic's Notice of Privacy Practices and declined but wish to continue my care with Tomball Vision Clinic under the terms of Tomball Vision Clinic's privacy policies.
- I have read or had explained to me Tomball Vision Clinic's Notice of Privacy Practice and do not wish to continue my care with Tomball 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:

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**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