ACKNOWLEDGEMENT
OF
NOTICE OF PRIVACY PRACTICES

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