LONE STAR
VISION ASSOCIATES P.A.

ACKNOWLEDGEMENT
OF
NOTICE OF PRIVACY PRACTICES

The law requires that Lone Star Vision Associates, P.A make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

PLEASE CHECK ONLY ONE ITEM.

- ☐ I have read or had explained to me Lone Star Vision Associates, P.A's Notice of Privacy Practice and agree to continue my care with Dr. Sundip Patel under said terms.
- ☐ I was given to opportunity to read Lone Star Vision Associates, P.A's Notice of Privacy Practices and declined but wish to continue my care with Lone Star Vision Associates, P.A under the terms of Lone Star Vision Associates, P.A's privacy policies.
- ☐ I have read or had explained to me Lone Star Vision Associates, P.A's Notice of Privacy Practice and **DO NOT WISH TO CONTINUE MY CARE WITH LONE STAR VISION ASSOCIATES, P.A 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