ACKNOWLEDGEMENT
OF
NOTICE OF PRIVACY PRACTICES

The law requires that Ohana Optometry 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 Ohana Optometry's Notice of Privacy Practice and agree to continue my care with Ohana Optometry under said terms.

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