ACKNOWLEDGEMENT
OF
NOTICE OF PRIVACY PRACTICES

The law requires that Palm Beach Eyes of Boynton Beach make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

Please check the ONE box that applies:

- ☐ I was given the opportunity and declined to read Palm Beach Eyes of Boynton Beach's Notice of Privacy Practices but wish to continue my care with Palm Beach Eyes of Boynton Beach under the terms of Palm Beach Eyes of Boynton Beach's privacy policies.

- ☐ I have read Palm Beach Eyes of Boynton Beach's Notice of Privacy Practice prior to any services offered and agree to continue my care with Palm Beach Eyes of Boynton Beach under said terms.

- ☐ I do not wish to continue my care with Palm Beach Eyes of Boynton Beach. I have read prior to any services offered Palm Beach Eyes of Boynton Beach's Notice of Privacy Practice and have decided not to continue my care with Palm Beach Eyes of Boynton Beach under said terms.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

______________________________________	____________________________
Patient Signature (Parent or Guardian)	Date
______________________________________	____________________________
Print Patient Name	Relationship to Patient (if applicable)