

**ACKNOWLEDGEMENT  
OF  
NOTICE OF PRIVACY PRACTICES**

The law requires that Crystal Vision Center, P.C. make every effort to inform you of your rights related to your personal health information. By signing below, I acknowledge that:

**(CHECK ONE BOX ONLY)**

- I have read or had explained to me Crystal Vision Center, P.C.'s Notice of Privacy Practice and agree to continue my care with Crystal Vision Center, P.C. under said terms.
  - I was given the opportunity to read Crystal Vision Center, P.C.'s Notice of Privacy Practices and declined but wish to continue my care with Crystal Vision Center, P.C.'s under the terms of Crystal Vision Center, P.C.'s privacy policies.
  - I have read or had explained to me Crystal Vision Center, P.C.'s Notice of Privacy Practice and do not wish to continue my care with Crystal Vision Center, P.C.'s 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
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In addition, if I am a student age 18-25 and covered under a parent or guardian's insurance policy, I authorize, Crystal Vision Center, P.C.'s to release information verbally or in writing regarding my diagnosis, treatment, payment, and benefits to any individual identifying herself/himself as my parent or guardian.

**I HAVE VOLUNTARILY 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

\_\_\_\_\_  
Date