

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

Select one:

- By signing below, I acknowledge that I have **received a copy** of the *Oregon Eye Specialists, PC Notice of Privacy Practices*.
- By signing below, I acknowledge that I was offered a copy of the *Oregon Eye Specialists, PC Notice of Privacy Practices* and I have **declined to take a copy** at this time.

_____	_____
<i>Patient Signature</i>	<i>Date</i>
_____	_____
<i>Print Patient Name</i>	<i>DOB</i>

OR

_____	_____
<i>Parent/Guardian/Responsible Party/<u>Legal Representative</u> Signature</i>	<i>Date</i>

<i>Print Representative's Name and Describe Authority</i>	