



Acknowledgement of Notice of Privacy Practices

The law requires that Ken Merchant OD, PLLC make every effort to inform you of your rights related to your personal health information. By signing below, I acknowledge that:

-Please Check One-

- I have read or had explained to me that Ken Merchant OD, PLLC's Notice of Privacy Practice and agree to continue my care with Ken Merchant OD, PLLC under said terms.
- I was given the opportunity to read Ken Merchants OD, PLLC's Notice of Privacy Practices and declined to, but wish to continue my care with Ken Merchant OD, PLLC under the terms of Ken Merchant OD, PLLC's policies.
- I have read or had explained to me Ken Merchant OD, PLLC's Notice of Privacy Practice and **DO NOT** wish to continue my care with Ken Merchant OD, PLLC under said terms.
- Ken Merchant OD, PLLC's Notice of Privacy Practices could not be read due to the emergent nature of the care of other reason described as:

My protected health information may be disclosed to: (Name & Relationship)

I have read and understand this form; and I am signing it voluntarily.

Patient Name (printed): _____

Patient's Signature: _____ Date: _____

*If you are signing as a personal representative of the patient, please indicate your name and your relationship to the patient.

Representative: _____

Relationship to Patient: _____