ACKNOWLEDGEMENT
OF
NOTICE OF PRIVACY PRACTICES

The law requires that Arnold M Stokol OD and Associates 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 was given the opportunity to read Arnold M Stokol OD and Associates' Notice of Privacy Practice and agree to continue my care with Arnold M Stokol OD and Associates under said terms.

Please indicate whether you would like a printed copy of our Notice of Privacy Practice by circling one of the options below:

I would like a copy **I do not want a copy**

_____
Print Name

_____ _____
Signature Date

If you are signing as a personal representative of the patient, please indicate your relationship

_____ _____
Representative Relationship to Patient

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

I give permission to release my records to the following people:

Name: _____ Relationship: _____

Name: _____ Relationship: _____