

**ACKNOWLEDGEMENT  
OF  
NOTICE OF PRIVACY PRACTICES**

The law requires that Steve Randle O.D., PLLC 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 had explained to me Steve Randle O.D., PLLC's Notice of Privacy Practice and agree to continue my care with Steve Randle O.D., PLLC under said terms.
- I was given to opportunity to read Steve Randle O.D., PLLC's Notice of Privacy Practices and declined but wish to continue my care with Steve Randle O.D., PLLC under the terms of Steve Randle O.D., PLLC's privacy policies.
- I have read or had explained to me Steve Randle O.D., PLLC's Notice of Privacy Practice and do not wish to continue my care with Steve Randle O.D., PLLC 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

\_\_\_\_\_  
\_\_\_\_\_

I HAVE 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

\_\_\_\_\_  
Relationship to Patient