ACKNOWLEDGEMENT
OF
NOTICE OF PRIVACY PRACTICES

The law requires that Jerome E. Gundersheimer, O. D. - Doctor of Optometry 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 Jerome E. Gundersheimer, O. D. - Doctor of Optometry's Notice of Privacy Practice and agree to continue my care with Jerome E. Gundersheimer, O. D. - Doctor of Optometry under said terms.
- ☐ I have read or had explained to me Jerome E. Gundersheimer, O. D. - Doctor of Optometry's Notice of Privacy Practice and do not wish to continue my care with Jerome E. Gundersheimer, O. D. - Doctor of Optometry 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