ACKNOWLEDGEMENT
OF
NOTICE OF PRIVACY PRACTICES

The law requires M.A. Shurtz OD & Associates make every effort to inform you of your rights related to your personal health information. The Notice of Privacy Practice description follows this form, or you may request a copy for your records.

By signing this form, you acknowledge that you have been provided access to M.A. Shurtz OD & Associates Notice of Privacy Practice.

_____
Print Patient Name

_____ _____
Signature Date

_____
Relationship to Patient
(if signing for a minor)