**DEKALB OPTOMETRIC ASSOCIATES, PC**
**121 E. LOCUST ST.**
**DEKALB, IL 60115**
**PH: 815-756-6388**
**FAX: 815-756-4861**
**EMAIL: STAFF@DEKALB-OPTOMETRIC.COM**
**WWW.DEKALBOPTOMETRIC.COM**

# ACKNOWLEDGMENT OF RECEIPT of the Notice of Privacy Practices of DEKALB OPTOMETRIC ASSOCIATES, PC

I acknowledge that I have received or been offered the Notice of Privacy Practices of DeKalb Optometric Associates, PC. I understand that the Notice describes the uses and disclosures of my protected health information by the Covered Entities which collectively constitute DeKalb Optometric and informs me of my rights with respect to my protected health information.

________________________________________ ________________
**Name of Patient** **Date of Birth**

________________________________________
**Signature of Patient or Personal Representative**

________________________________________ ________________
**Printed Name of Patient or Personal Representative** **Date**

**If Personal Representative, indicate relationship:**

________________________________________

## Declinations

☐ The Individual declined to accept a copy of the Notice of Privacy Practices.

☐ The Individual received a copy of the Notice of Privacy Practices but declined to sign an acknowledgment of receipt.

________________________________________ ________________________________________
Signature of DeKalb Optometric Represenative Name of DeKalb Optometric Represenative