Acknowledgment of Notice of Privacy Practices

The law requires that this Vision Source practice make every effort to inform you of your rights related to your personal health information.

By signing below, I acknowledge that:

____ I was given the opportunity to read, have read or had explained to me this Vision Source practice's Notice of Privacy Practice prior to any services offered.

___ The Notice of Privacy Practice could not be read due to the emergent nature of the care and will be acquired when possible.

I authorize this Vision Source practice to release my personal health information to the following individuals:

_____ _____

Our office may use standard email and text messaging to communicate with you. These forms of communication are not secure and do not guarantee privacy.

___ I authorize the use of these forms of communication, despite the known risk involved, to communicate with me.

___ I do not authorize the use of these forms of communication to communicate with me.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

_____ _____

Patient Signature Date

If you are signing as a personal representative of the patient, please indicate your relationship. If you are signing for a minor, you attest that you have legal authority to make medical decisions for the minor.

_____ _____

Representative Signature Relationship to Patient