ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

(to be filed in patient's medical record)

I have been presented with a copy of the Notice of Privacy Practices outlining my rights regarding my health information and detailing how my health information may be used and disclosed as permitted under federal and state law.

By law, without your authorization, The Vision Center cannot communicate with:

- Your spouse
- Your adult children or caregivers
- Your parents (if age 18 or older)
- Your other healthcare physicians

Indicate below the names of the people who we may communicate with regarding your appointment, medical/vision or account information:

☐ Spouse: _____

☐ Adult Children: _____

☐ Parents/Caregivers: _____

☐ Health Care Physicians: _____

☐ Other: _____

Patient or Guardian signature: _____ Date: _____

Relationship (if not signed by patient): _____

Internal Use Only

If patient / patient's representative refused to sign acknowledgement, please document the date and time notice was presented to patient and sign below.

Presented on (date and time): _____

By (name and title): _____