ACKNOWLEDGEMENT
OF
NOTICE OF PRIVACY PRACTICES

The law requires that Eyecare Specialties make every effort to inform you of your rights related to your personal health information. By signing below, I acknowledge that:

☐ I have read or had explained to me Eyecare Specialties Notice of Privacy Practice and agree to continue my care with Eyecare Specialties under said terms.

Office use only

☐ The Notice of Privacy Practice could not be read due to the emergent nature of the care or other reason described as

_____

I authorize Eyecare Specialties to release/discuss my protected health information with my family member(s) or caretaker(s) as listed below:

Name Relationship to patient

_____

_____

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

Patient Name (Printed) _____

Patient (Signature) _____

Guardian (Signature) _____

Relationship to Patient_____ Date_____