Acknowledgment of Notice of Privacy Practices

Family Eye Care Clinic
719 W Main St. Atlanta TX 75551
903-796-8288

The law requires that Family Eye Care Clinic make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

____I was given the opportunity to read, have read or had explained to me Family Eye Care Clinic'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 Family Eye Care Clinic to release my personal health information to the following individuals:

_____ / Relationship to Patient _____

_____ / Relationship To Patient _____

My vision plan requests that all diagnoses related to any medical condition I may have be released to them. As a non-traditional disclosure, release of this information requires my specific authorization:

___ I authorize the release of medical information to my vision plan
___ I do not authorize release of medical information to my vision plan

Our office may use texts and emails to communicate with you. Although HIPAA compliant, they may not be encrypted and complete privacy cannot be guaranteed.

___ I authorize the use of text and email.
___ I do not authorize the use of text and email 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 the legal authority to make medical decisions for the minor and consent to such care. Please indicate any other parent, step-parent, guardian or other individual(s) authorized to make medical decisions for the minor.

_____ / _____
Representative Signature / Relationship to Patient

_____
Other individuals authorized to make legal decisions for the minor