ACKNOWLEDGEMENT OF
NOTICE OF PRIVACY PRACTICES

The law requires that Primary Eye Care Center I, LLP 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 Primary Eye Care Center I, LLP's Notice of Privacy Practices prior to any services offered.
- ☐ The Notice of Privacy Practice could not be read to the emergent nature of the care and will be acquired when possible.

I authorize Primary Eye Care Center I, LLP to release my personal health information to the following individuals:

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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 legal authority to make medical decisions for the minor. Please indicate any other parent, step-parent, guardian or other individual(s) authorized to make medical decisions for the minor.

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Representative Signature Patient Name Relationship to Patient