Acknowledgment of Notice of Privacy Practices

Patient Name ______________________________

Premier Vision, P.C.
152 Ninth Street, Terrell, TX 75160 Terrell TX 75160
972-563-5533

The law requires that Premier Vision, P.C. 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 Premier Vision, P.C.'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 Premier Vision, P.C. to release my personal health information to the following individuals:

______________________ ______________________________

If 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 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

____
Representative Signature

____
Relationship to Patient