VISION SOURCE®

ACKNOWLEDGEMENT
OF
NOTICE OF PRIVACY PRACTICES

The law requires that La Pine Eyecare Clinic make every effort to inform you of your rights related to your personal health information. These rights are explained in La Pine Eyecare Clinic's Notice of Privacy Practices. By signing below, I acknowledge that:

- ☐ I have read, been given the opportunity to read but declined, or had La Pine Eyecare Clinic's Notice of Privacy Practices explained to me and agree to continue my care with La Pine Eyecare Clinic under said terms.
- ☐ Knowing that standard email and text communication may not be totally secure, I still consent to communications from my doctor or staff through standard email and texting systems/devices.

I understand that the Notice of Privacy may be revised from time to time and that I am entitled to receipt a copy of any revised Notice of Privacy Practices upon request and that a copy of the most current version of the clinic's Notice of Privacy Practice in effect will be posted in the waiting/reception area.

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

_____ _____

Patient Signature **Date**

_____

Printed Name

(If you are signing as a personal representative of the patient, please indicate your relationship)

_____ _____

Representative Signature Printed Name

_____

Relationship to Patient (parent, spouse, POA)

For Office Use Only:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ☐ Patient refused to sign our Clinic's Notice of Privacy Practices and does not wish to continue his/her care with La Pine Eyecare Clinic under said terms.
- ☐ The Notice of Privacy Practice could not be read due to the emergent nature of the visit preventing us from obtaining acknowledgment
- ☐ Other_____