Vision Source
6956 Garth Rd.
Baytown, TX 77521
Ph. (281) 421-1243 Fax (281) 421-7262

Acknowledgment of Notice of Privacy Practices

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

(CHECK ONE ONLY)

- o I have read or had explained to me Family Vision Center's Notice of Privacy Practices and agree to continue my care with Family Vision Center under said terms.
- o I was given an opportunity to read Family Vision Center's Notice of Privacy Practices and decline but wish to continue my care with Family Vision Center under the terms of Family Vision Center's privacy practices.
- o I have read or had explained to me Family Vision Center's Notice of Privacy Practices and do not wish to continue my care with Family Vision Center under said terms.
- o The Notice of Privacy Practices could not be read to the emergent nature of the care of other reason described as

____.

Message: We will use all numbers on file to contact you. If unable to reach you, we will leave a detailed message concerning the status of products, glasses, and contacts.

Medical Information Release Form (HIPAA Release Form)

I authorize the release of information including the diagnosis, records, examination rendered to me, and claims information. This information may be released to:

(WRITE-OUT FULL NAMES)

- o Spouse
  ____
- o Child(ren)
  ____
- o Other
  ____
- o Information is not to be released to anyone.

This release of information will remain in effect until terminated in writing.

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

____
____
Patient Date

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

____
___________________________________ Representative
Relationship to Patient