Notice of Privacy Practices – Acknowledgment

Dimond Vision Clinic keeps a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting our Front Desk. Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information.

By signing below, I acknowledge that I have received the Notice of Privacy Practices:

_____ _____

Printed name of patient | Signature of patient or legally authorized individual

_____ _____

Printed name if signed on behalf of patient | Date

IF APPLICABLE: AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

PURPOSE: For release of protected health information to a third party not involved with the payment, treatment or health care operations of the patient.

I authorize Dimond Vision Clinic to release my personal health information to the following individual(s) or facility:

_____ _____

Name | Relationship

_____ _____

Name | Relationship

_____ _____

Name | Relationship