Visualize Optometry

Acknowledgement Notice of Privacy Practices

Patient Name:_____
Patient Address:_____
Patient Phone Number:_____

Signing this document signifies that you have received a copy of our Notice of Privacy Practices

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for these services, and to conduct healthcare operations involving our office. The ***Notice of Privacy Practices*** you have been given describes these uses and disclosures in detail. *Int*_____

Requested Disclosure OPTION:

If you would like Visualize Optometry to disclose information regarding your care and treatment, the names of said person/s must be included below. Examples of information would include copies of receipts, prescriptions, records or products including contact lenses:

Name of Person/s:_____

Record Retention Policy

We are informing you that our office will keep all records on file for **5 years** from the date of last examination. *Int*____

Signature:_____ Date:_____

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form:

Relationship to Patient:_____
Print Name:_____