FAMILY VISION ASSOCIATES
YOUR VISION IS OUR FOCUS™

Notice of Privacy Policies – Patient Acknowledgement

Patient Name: _____ Date of Birth: _____

1. I have received the Notice of Privacy Practices. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, and the practice's legal duties with respect to my information.

2. I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at or controlled by this practice. I understand I can obtain this practice's current Notice of Privacy Practices on request.

3. I designate the persons listed below as individuals involved in my healthcare and authorize this practice to discuss private health information as well as discuss financial information regarding payment with Family Vision Associates. I understand that I may change this list at any time by submitting a written request. *(Family Vision Associates will not be allowed to discuss **anything** with anyone that you do not list below even if they are calling on your behalf.)*

   Name: _____ Relationship: _____

   Name: _____ Relationship: _____

   Name: _____ Relationship: _____

4. I designate below the phone numbers where Family Vision Associates can contact me to receive or discuss private healthcare information and/or payment information.

Telephone Number	Leave Message
Home: _____	Yes / No
Work: _____	Yes / No
Cell: _____	Yes / No

Patient/Guardian Signature: _____ Date: _____