

# Acknowledgment of Notice of Privacy Practices

Montgomery Vision Source  
123 Blue Heron Dr. #103 Montgomery TX 77316  
936-582-4200

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

**I was given** the opportunity to read, have read or had explained to me Montgomery Vision Source's Notice of Privacy Practice (located on clipboard) prior to any services offered.

**OR**

The Notice of Privacy Practice **could not be read** due to the emergent nature of the care and will be acquired when possible.

I authorize Montgomery Vision Source to release my personal health information to the following individuals:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

My vision plan requests that all diagnoses related to any medical condition I may have be released to them. As a non-traditional disclosure, release of this information requires my specific authorization:

**I authorize** the release of medical information to my vision plan

**I do not authorize** release of medical information to my vision plan

Our office may use texts and emails to communicate with you. Although HIPAA compliant, they may not be encrypted, and complete privacy cannot be guaranteed.

**I authorize** the use of text and email.

**I do not authorize** the use of text and email to communicate with me.

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

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
**Patient Name**                                              **Patient Signature**                                              **Date**

If you are signing as a personal representative of the patient, please indicate your relationship. **If you are signing for a minor, you attest that you have the legal authority to make medical decisions for the minor and consent to such care.** Please indicate any other parent, step-parent, guardian or other individual(s) authorized to make medical decisions for the minor.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
**Representative Name**                                              **Representative Signature**                                              **Relationship to Patient**

Other individuals authorized to make legal decisions for the minor