

Acknowledgment of Notice of Privacy Practices

Sharonville Evendale Eyecare Center, Inc.
10675 McSwain Drive
Cincinnati, OH 45241
513-563-2304

The law requires that Sharonville Evendale Eyecare Center, Inc. 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 Sharonville Evendale Eyecare Center, Inc.'s Notice of Privacy Practice prior to any services offered.

☐ 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 Sharonville Evendale Eyecare Center, Inc. to release my personal health information to the following individuals:

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 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 Signature / Relationship to Patient

Other individuals authorized to make legal decisions for the minor:

