Bella Vista EYECARE ASSOCIATES

"Helping your family SEE the beauty in life"

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

The law requires that Bella Vista Eyecare Associates make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

☐ I have read or had explained to me Bella Vista Eyecare Associates' Notice of Privacy Practice and agree to continue my care with Bella Vista Eyecare Associates under said terms.

☐ I was given the opportunity to read Bella Vista Eyecare Associates' Notice of Privacy Practices and declined but wish to continue my care with Bella Vista Eyecare Associates under the terms of Bella vista Eyecare Associates' privacy policies.

☐ I have read or had explained to me Bella Vista Eyecare Associates' Notice of Privacy Practice and ***do not wish to continue*** my care with Bella Vista Eyecare Associates under said terms.

☐ The Notice of Privacy Practice could ***not*** be read to the emergent nature of the care or other reason described as

_____

_____

I authorize Bella Vista Eyecare Associates to disclose private health information regarding my eyes, payments, orders, etc. to the following people:

1)_____

2)_____

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

_____ _____

Patient Date

If you are signing as a personal representative of the patient, please indicate your relationship.

_____ _____

Representative Relationship to Patient