Premier Vision Partners

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ACKNOWLEDGEMENT OF RECEIPT

OF NOTICE OF PRIVACY PRACTICES

PREMIER VISION PARTNERS

As provisioned by the *Health Insurance Portability and Accountability Act of 1996* we must provide you with a detailed notice, in writing, of our privacy practices. By signing this notice, you have acknowledged receipt of our 'Notice of Privacy Practices'. If you would like a copy of our Notice of Privacy Practices to take with you, please let one of our associates know.

If you would like to authorize another individual or facility to access your medical records from Premier Vision Partners, please list them below. Any persons listed below may have access to the following protected health information: prescriptions, office visit notes, financial information, personal information, and/or picking up products.

Name: _____Relationship: _____

Name: _____Relationship: _____

Name: _____Relationship: _____

Name: _____Relationship: _____

I, _____, hereby acknowledge receipt of the *Notice of Privacy Practices Policy of Premier Vision Partners.* By signing this form, I authorize Premier Vision Partners to obtain medical and prescription information from outside sources and to release medical information necessary to process my claims, including information for any healthcare related utilization or quality assurance activities without my additional consent.

_____

Patient or Parent/Guardian Signature

_____

Date

This acknowledgement page should be retained in the patient's record.
If an acknowledgement could not be obtained from the patient, note the reasons below.

_____

_____