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ACKNOWLEDGMENT OF PRIVACY PRACTICES, RELEASE OF PATIENT INFORMATION, AND OFFICE POLICIES

By law, HD Eyecare, PLLC, is required to make every effort to inform you of your rights related to your personal health information. Without your permission, we will not discuss any part of your eyecare conditions with any person including family members (with the exception of parents/guardians of minor children).

I consent and authorize the release of any personal health information to the following persons:

Name: _____Relationship: _____

Name: _____Relationship: _____

Name: _____Relationship: _____

I acknowledge that I have been presented a copy or had explained to me the Office Policies and Notice of Privacy Practices for HD Eyecare, PLLC. I consent for HD Eyecare, PLLC, to communicate with me via email and text messages when convenient and make every effort to safeguard my protected health information. However, I understand that a third party may be able to access my protected health information.

Patient Name: _____ Relationship: _____

Signature: _____ Date: _____