Vision Source™

ALBANY • BLAKELY • CAMILLA

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

The law requires that 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 give Vision Source my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies and for health care operations.

I have read or had explained to me Vision Source's Notice of Privacy Practice and agree to continue my care with Vision Source under said terms.

I have been informed that I may review Vision Source's Notice of Privacy Practices and that I may obtain any revised notices at Vision Source.

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**

_____

Emergency Contact Name **Relationship** **Phone Number**