Family Eye Care

Acknowledgment of Receipt of Notice of Privacy Practices

By my signature below, I acknowledge that I have received Family Eye Care's Notice of Privacy Practices.

Patient Name: ___________________________Patient Date of Birth _________________

Any physician, staff, employee or representative of Family Eye Care has my permission to **discuss** my account and medical conditions which may include symptoms, treatments, diagnosis, test results, medications or any other type of protected health information with the following persons in order to facilitate and coordinate my care, treatment and payment.

Name	Relationship	Phone Number(s)

I understand that authorizing the release of my information to the above individual(s) is voluntary and does not affect my access to treatment. I can refuse to sign this form. I can revoke in writing to Family Eye Care or completing a new form at any time. This authorization will remain in effect until I change or Revoke it. I understand that if information is shared with the above individuals it may be subject to re-disclosure by the individuals.

Patient or Guardian's Signature _____________________________ Date: ______________

We use SOLUTIONREACH network to communicate electronically with our patients via email and texts. This network can notify you of your future appointments and also alerts you electronically when your glasses and/or contacts order is ready for pick-up.

Can we communicate with you via email? ____YES ____NO

Can we communicate with you via texts? ____YES ____NO _____No, I do not text.

Please update information below:

Address____

Cell phone ____

Email Address_____________________________________

Who Can We Release Glasses, Contacts, or Prescriptions To:

Name: ________________________ Relationship: ________________________Phone number: _______________________

Name: ________________________ Relationship: ________________________Phone number: _______________________

Name: ________________________ Relationship: ________________________Phone number: _______________________

Patient or Guardian's Signature __________________________________ Date: ______________