Acknowledgment of Notice of Privacy Practices

Swartz Family Eyecare, LLC
2150 Ewing Crawfis Circle
Bellefontaine, Ohio 43311
937-593-1766

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

____I was given the opportunity to read, have read or had explained to me Swartz Family Eyecare, LLC's Notice of Privacy Practice prior to any services offered.

___ The Notice of Privacy Practice could not be read due to the emergent nature of the care and will be acquired when possible

I authorize Swartz Family Eyecare, LLC to release my personal health information to the following individuals:

_____ _____

_____

My vision plan requests that all diagnoses related to any medical condition I may have be released to them. As a non-traditional disclosure, release of this information requires my specific authorization:

___ I authorize the release of medical information to my vision plan

___ I do not authorize release of medical information to my vision plan

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

_____ \ _____

Patient Signature Date

If you are signing as a personal representative of the patient, please indicate your relationship. If you are signing for a minor, you attest that you have legal authority to make medical decisions for the minor.

Relationship to patient _____

_____ \ _____

Representative Signature Relationship to Patient Date