

# Acknowledgment of Notice of Privacy Practices

Fremont Vision Source  
215 E 22nd Street, Fremont, NE 68025  
402-721-8032

The law requires that Fremont 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 was given the opportunity to read, have read or had explained to me Fremont Vision Source'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 Fremont Vision Source to release my personal health information to the following individuals:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

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

\_\_\_\_\_  
Representative Signature

\_\_\_\_\_  
Date:

\_\_\_\_\_  
Relationship to Patient