Acknowledgment of Notice of Privacy Practices

Fremont Vision Source
2955 E Elk Lane Fremont, NE 68025
402-721-8032

I read or was given the opportunity to read Fremont Vision Source's Notice of Privacy Practices prior to any services offered.

___ The Notice of Privacy Practices 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:_____

Our office may use texts and emails to communicate with you. Although HIPAA compliant, they may not be encrypted and complete privacy cannot be guaranteed.

___ I authorize the use of text and email
___ I do not authorize the use of text and email to communicate with me

___ I authorize the release of reproductive health information, including surgeries, procedures and birth control measures as part of my complete medical record
___ I do NOT authorize the release of reproductive health information, including surgeries, procedures and birth control measures as part of my complete medical record

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

_____ / _____ / _____
Patient Name (Print) 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 the legal authority to make medical decisions for the minor and consent to such care. Please indicate any other parent, step-parent, guardian or other individual(s) authorized to make medical decisions for the minor.

_____ / _____ / _____
Representative Name (Print) Representative Signature Relationship

_____
Other individuals authorized to make legal decisions for the minor