# 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 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:_____

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 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.**

_____ _____
Representative Name (Print) Relationship to Patient

_____ _____
Representative Signature Date

Please indicate any other parent, step-parent, guardian or other individual(s) authorized to make medical decisions for the minor.

_____ _____
Other Individual Authorized Name (print) Relationship

_____ _____
Other Individual Authorized Name (print) Relationship