The Eye Institute of Reston

DOCTORS OF OPTOMETRY
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Acknowledgement of Notice of Privacy Practices

The law requires that Eye Institute of Reston 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 Eye Institute of Reston'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

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

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.

May we leave a message on your answering machine at home or on your cell phone? **Yes** **No**

May we discuss your medical condition with any member of your family? **Yes** **No**

If YES, please name the members allowed: ______________________________

Emergency Contact: ______________________________ ***Contact #:*** ______________________________

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

______________________________ ______________________________

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 Signature/ Relationship to patient **Date**

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Other individuals authorized to make legal decisions for the minor