WRIGHT
EYE CARE CENTER

❑ J. Britt Wright, OD
Therapuetic Optometrist
Optometric Glaucoma Specialist

❑ Stephen G. Slade, MD
Surgical Director

ACKNOWLEDGEMENT OF "NOTICE OF PRIVACY PRACTICES"

❍ **I read or was given the opportunity to read, Wright Eye Care, PLLC'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 Wright Eye Care, PLLC 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 the release of medical information to my vision plan

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 AND I AM SIGNING IT VOLUNTARILY.

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Patient **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.

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Representative Relationship Date

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Other individuals authorized to make legal decisions for the minor