Jeffrey D. Horn, MD
VISION FOR LIFE

HIPAA ACKNOWLEDGEMENT FORM

I am a patient of Vision for Life. I hereby acknowledge receipt of Vision for Life's Notice of Privacy Practices.

Name (please print): _____

Signature: _____

Date: _____

OR

I am a legal guardian of _____ (patient name). I hereby acknowledge receipt of Vision for Life's Notice of Privacy Practices with respect to this patient.

Name (please print): _____

Relationship to Patient: □ Parent □ Legal Guardian

Signature: _____

Date: _____

PATIENT COMMUNICATION FORM

A. Family and Friends. It is the office policy of Vision for Life not to release confidential medical information regarding your treatment to family members or friends, except for (i) parent/legal guardian, (ii) other persons authorized by the patient, (iii) as we may reasonably infer from the circumstances (for example, if you bring a family member or friend into the exam room, we will assume, unless you object, that that person is entitled to receive information regarding your treatment, (iv) in emergency situations, or (v) other as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

If you anticipate that you will need or want your medical information to be provided to family members, friends, or caretakers, please indicate that below, so that we may best serve you. If you do not want any of your medical information provided to a family member, please check (√) the line next to the "no" response. By signing below, you authorize the following people to receive information regarding your treatment or care. (If you wish to add names later on, please confirm this in writing, or call our staff.)

Spouse: _____ Phone: _____ ____yes ____no

Parent: _____ Phone: _____ ____yes ____no

Other: _____ Phone: _____ ____yes ____no

By listing an email or cell phone number, you agree to receive marketing materials from Vision for Life. For more information on Vision for Life's privacy policy, please visit www.visionforlife.com/notice-of-privacy-policy.

PATIENT NAME (please print) _____

PATIENT EMAIL ADDRESS: _____

CELL PHONE: _____

PATIENT SIGNATURE: _____ DATE: _____

FOR OFFICE USE:

Changes to above authorized by patient over phone:

Change: _____ Date: _____ Staff Initials: _____