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 (attached).

Name (please print): _____

Email Address: _____

Cell Phone: _____

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: ☐ **Parent** ☐ **Legal Guardian**

Email Address: _____

Cell Phone: _____

Signature: _____

Date: _____

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