Acknowledgement of Notice of Privacy Practices
Betts and DeMott Eye Care & Optical Boutique

Print Name: _____

Phone Number: _____

Email Address: _____

☐ By checking this box, I understand that this office uses standard, unencrypted email to send requested invoices, spectacle/contact prescriptions, etc.

The law requires that Betts and DeMott Eye Care & Optical Boutique make every effort to inform you of your rights related to your personal health information. By signing below, I acknowledge that:

_____ I was given the opportunity to read, have read or had explained to me Betts and Biddle Eye Care PA'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 Betts and DeMott Eye Care & Optical Boutique to release my personal health information to the following individuals:

_____

My insurance 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.

☐ **By checking this box, I authorize the release of medical information to my insurance plan.**

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

_____ _____

Patient Signature Date

If you are signing as a personal representative of the patient, please indicate your relationship below. If you are signing for a minor, you attest that you have legal authority to make medical decisions for the minor.

_____ _____

Representative Signature Relationship to Patient