

Acknowledgment of Notice of Privacy Practices

Envision Eye and Wellness, LLC
8035 Team Dr, Ste 5 Maria Stein, OH 45860
419.210.5675

I read or was given the opportunity to read Envision Eye and Wellness, LLC's Notice of Privacy Practices prior to any services offered.

☐ The Notice of Privacy Practices could not be read due to the emergent nature of the care and will be acquired when possible.

I authorize Envision Eye and Wellness, LLC 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 release of medical information to my vision plan

Our office may use texts and emails to communicate with you. These texts or emails may not be encrypted and therefore complete privacy cannot be guaranteed.

- ☐ I authorize the use of unsecured text and email
- ☐ I do not authorize the use of unsecured text and email to communicate with me

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. 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

Other individuals authorized to make legal decisions for the minor
Other individuals authorized to make legal decisions for the minor