Acknowledgment of Notice of Privacy Practices

McClurg Vision Center
10721 Chapman Hwy #5 Seymour, TN 37865
865-577-6650

I read or was given the opportunity to read McClurg Vision Center'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 McClurg Vision Center to release my personal health information to the following individuals:

_____
_____
_____

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