Acknowledgment of Notice of Privacy Practices

Basin Vision Center, P.C.
620 19th Street Cody, WY 82414
307-587-4206

The law requires that Basin Vision Center, P.C. make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

___ I was given the opportunity to read, have read, or have explained to me Basin Vision Center, P.C.'s Notice of Privacy Practices prior to any services offered.
___ The Notice of Privacy Practice could not be read due to the emergent nature of care and will be acquired when possible.

I authorize Basin Vision Center, P.C. to release my personal health information to the following individuals:

_____ _____ _____

Our office may use texts and emails to communicate with you. Although HIPAA compliant, they may not be encrypted and complete privacy cannot be guaranteed.
___ I authorize the use of text and email communication.
___ I do not authorize the use of text and email communication.

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

_____ _____
Patient name (printed) Date

_____ _____
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 and relationship to patient Date

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