AMERICAN FAMILY VISION CLINIC

406 Lilly Rd NE Suite A, Olympia, WA 98506

ACKNOWLEDGEMENT OF THE NOTICE OF PRIVACY PRACTICES

I have been informed of my medical provider's *Notice of Privacy Practices,* which is part of the Health Insurance Portability & Accountability Act of 1996 (HIPAA). It contains a complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices* upon request. I understand that my medical provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the ***Notice of Privacy Practices.***

My signature confirms that I agree to AFVC's Privacy Practices and I understand that my healthcare information may be shared with other healthcare professionals upon their request without additional signatures from me.

Patient Name:_____D.O.B_____Date:_____
Print Name

Signature:_____

Relationship to Patient:_____

DISCLOSURE TO FAMILY AND/OR FRIENDS DOCUMENTATION FORM

Family Members/Friends involved in my care:

____I Agree that American Family Vision Clinic may disclose by **phone or in person** my private health information, including billing information, to only the following individuals listed below.

(Check all that apply)

____Spouse_____
Print Name

____Parents_____
Print Name

____Children_____
Print Name

____Caregiver/Guardian/Other_____
Print Name

____I do not want my private health information disclosed to any family member or friend.

Signature_____

This authorization is good for 2 years. It is your responsibility to notify AFVC if you want to make changes before the expiration date.

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