Acknowledgement of Privacy Practices

The law requires that Olson Eye Care 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 had explained to me Olson Eye Care's Notice of Privacy Practice prior to any services offered

This form allows Olson Eye Care to discuss your protected health information with the person(s) you appoint as your personal representative(s).

Name: _____ Relationship:_____ DOB: _____

Please check all that apply:

- ☐ Medical Information
- ☐ Financial Information
- ☐ Pickup of Materials Purchased

Name: _____ Relationship:_____ DOB: _____

Please check all that apply:

- ☐ Medical Information
- ☐ Financial Information
- ☐ Pickup of Materials Purchased

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

_____ _____

Signature Date

_____

Relationship if not Patient

I AGREE THAT THESE PROVISIONS WILL REMAIN IN EFFECT UNTIL I PROVIDE WRITTEN REVOCATION TO OLSON EYE CARE.