Georgia Vision Center

VISION SOURCE®

Notice of Privacy Practices Acknowledgement (HIPAA)

Our notice of Privacy Practices provides information about how we may use and release protected health information about you. You have the right to review our notice before signing this form. As provided in our notice, the terms are subject to change. If we change our notice, you may obtain a copy by writing to our office with your request.

You have the right to request that we restrict how your protected health information is used or released for treatment, payment or health care operations. We are not required to agree to this restriction but, if we do agree, we are bound by our agreement.

By signing this form, you consent to our use of protected health information as described in our notice. You have the right to revoke this consent in writing, with the exception of where we have already made releases in reliance on your prior consent.

Patient Name (Please Print): _____

Patient Signature: _____ Date: _____