PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

I authorize Windsor Eye Care to discuss/release my medical information including but not limited to current prescription, exam dates/history, insurance coverage, account balance, and medical records to the following persons:

Name_____ Relationship _____

Name_____ Relationship _____

Patient Name_____ Birthdate _____

Patient/Gaurdian Signature_____

WINDSOR
EYE CARE
& VISION CENTER