ACKNOWLEDGMENT OF RECEIPT
of
NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

_____ _____

Patient Name (please print) Date

_____

Parent or Authorized Representative (if applicable)

_____

Signature

Authorization for Co-Participation of Health Care

I,_____ _____ _____

Print patient's name Date of Birth Patients Phone Number

Authorize Kennewick Vision Care to discuss my health care and other protected information as indicated to the designated person(s) below.

_____	_____	_____	_____
Co-Participant Name	Contact Number	Relationship	Date of Birth
_____	_____	_____	_____
Co-Participant Name	Contact Number	Relationship	Date of Birth

Information Authorized:

( ) ALL Health Care Information

( ) Diagnosis ( ) Appointment Information

( ) Treatment ( ) Insurance/Reimbursement

( ) Lab Work ( ) Other: Please Specify

I understand that I must present suitable photo identification when requesting this release of confidential information.

_____ _____

Patient Signature Date

_____ _____

Parent/Legal Guardian Date