# Promontory Family Vision

## Acknowledgement of Notice of Privacy Practice
## (HIPAA LAW)

I acknowledge that I have read and understand and/or received a copy of the HIPAA Notice of Privacy Practices. I have been given the opportunity to ask questions about the use and disclosure of my health information, and/or other concerns regarding my health information. For HIPAA compliance, if there is anyone else that you authorized to have access to your medical records or would like us to speak to on your behalf, please list their name and date of birth. This will be kept on file until we received a written notice from the patient.

**Print Name:** ______________________________________________________________

**Patient Signature:**__________________________________________________________

**Date:** ____________________________________________________________________

## Consent Authorization of Medical Records Access

The patient has given consent to the following person/persons, to access and speak with in their name regarding the patient's medical records.

**Print Name:**_______________________________________________________________

**DOB:** ____________________________________________________________________

**Print Name:**_______________________________________________________________

**DOB:** ____________________________________________________________________

**Print Name:**_______________________________________________________________

**DOB:** ____________________________________________________________________