ACKNOWLEDGEMENT OF NOTIFICATION
OF PATIENT'S RIGHTS TO PRIVACY

I acknowledge that I have been notified of ClearVision Centers' Notification of Patient's Rights to Privacy.

Patient Name: _____ Account #: _____

Signature: _____ Date: _____

To allow ClearVision Centers to discuss your medical condition, treatment plan, surgery plan, appointment dates and times, etc. with a family member or other person involved in your health care, please list their names and their relationship to you below. You are not required to list anyone.

I authorize ClearVision Centers to release health information identifying me to the family members or other persons I have listed below:

Name_____Relationship_____Phone_____

Name_____ Relationship _____Phone_____