Acknowledgment Of Receipt
Of
NOTICE OF PRIVACY PRACTICE
for
Protected Health Information
AND
"PERMISSION TO TREAT MINOR CHILD" AUTHORIZATION

With the new privacy regulations in effect, it is now necessary to obtain permission in writing by whom we are allowed to release their personal health information to. We also recognize that it is sometimes necessary for people other than parents to bring in minor children (under 18) for visits. Again, with the new privacy regulations, we must have permission from the parent/guardian to examine, diagnose, and treat your minor child (under 18), and to whom we may release information to.
List as few or as many people as you would like.
This notice will remain in effect until revoked by patient/guardian.

_____ _____
_____ _____
_____ _____

I acknowledge that I have received a copy of the **FAMILY VISION DEVELOPMENT CENTER'S** ***Notice of Privacy Practices for Protected Health Services*** *on the date set forth below.*

_____ _____
Date of Receipt Signature of Patient

_____ _____
Patient's Name Signature of Authorized Guardian

FOR USE BY FAMILY VISION DEVELOPMENT CENTER ONLY

An Acknowledgment of Receipt of Notice of Privacy Practices was not obtained because:

☐ Patient refused to sign Acknowledgment

☐ Other - Please indicate reason: _____

_____ _____
Signature of Office Representative *Date*

Revised Jun/2017