ENVISION FAMILY EYECARE, PLLC
333 E. Harper Ave.
Maryville, TN 37804
Phone (865)982-6110, Fax (865)977-7243

Gary L. Vines, O.D. Timothy B. Spicer, O.D.

ACKNOWLEDGEMENT OF PRIVACY POLICY AND PRACTICES

I understand that in an attempt to protect the privacy of my identifiable health information, **EnVision Family Eyecare, PLLC** has established a *Privacy Policy* and guidelines for *Privacy Practices* within their office(s). This information details the use and/or disclosure of information contained in my personal medical/optometric records kept for the purposes of diagnosis, treatment, payment and health care operations. In accordance with HIPAA Regulations, a copy of the **EnVision Family Eyecare, PLLC** *Privacy Policy & Practices* has been made available to me while in the office today. Should I choose to have a personal copy, one will be given to me at no charge.

ATTENTION: PATIENT OR PATIENT REPRESENTATIVE PLEASE CHECK THE FOLLOWING:

I understand that the Practice may wish to contact me for purposes related to my treatment such as to remind me of appointments, leave messages that the physicians or nurse need to speak with me, to discuss financial/billing businesses, or to indicate other necessary contacts.

Please Check:

_____ Yes, **I authorize the Practice to contact me at the telephone numbers and/or email address I have provided. I understand and authorize the Practice to leave me a voicemail, email and/or text message(s) in the event that I am unavailable.**

_____ No, I do not agree to these contacts. Do not leave a message.

I understand that I may withdraw my authorization in writing to the Privacy Officer of the Practice at any time, except to the extent that action has been taken in reliance on this statement. I understand that even if I do not withdraw authorization that this statement will expire ***five (5) years from this date.*** I have carefully read and understand the above, and do herein expressly and voluntarily authorize the disclosure of the above information about, or medical records of, my condition to those persons or agencies listed below.

By signing below, I acknowledge that I have read or had explained to me EnVision Family Eyecare, PLLC's Notice of Privacy Practice and agree to continue care with EnVision Family Eyecare, PLLC under said terms.

_____
Name of patient (please print)

_____ _____
Signature of patient or patient's representative **Date**
(Form MUST be completed before signing.)

_____ _____
Name **Relationship to patient**

_____ _____
Name **Relationship to patient**