



**ACKNOWLEDGEMENT
OF
NOTICE OF PRIVACY PRACTICES**

The law requires that Hertneky Vision Source make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

- I have read or had explained to me Hertneky Vision Source’s Notice of Privacy Practice and agree to continue my care with Hertneky Vision Source under said terms.
- I was given the opportunity to read Hertneky Vision Source’s Notice of Privacy Practices and declined but wish to continue my care with Hertneky Vision Source under the terms of Hertneky Vision Source’s privacy policies.
- I have read or had explained to me Hertneky Vision Source’s Notice of Privacy Practice and do not wish to continue my care with Hertneky Vision Source under said terms.
- The Notice of Privacy Practice could not be read due to the emergent nature of the care of other reason described as

- Knowing that standard email and text communication may not be totally secure, I still consent to communications from my doctor or staff through my standard email and texting devices.
 - YES OR NO (circle one)
- I authorize Hertneky Vision Source to contact me by telephone or other media devices for communications needed to monitor my progress to recommended care.
 - YES OR NO (circle one)
- I give permission for Hertneky Vision Source to use my Name, Testimonial, or Image/Photograph in publications and advertisements produced by or for the practice now or in the future
 - YES OR NO (circle one)

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

Patient Name

Signature

Date



If you are signing as a personal representative of the patient, please indicate your relationship

Representative

Relationship to Patient