Visit www.dunbareye.com/privacy to review our Notice of Privacy Practices, or scan QR code at left with your smartphone for a direct link. Printed copies are available upon request.

Acknowledgment of Notice of Privacy Practices

The law requires that Dunbar Eye Associates, PLLC, make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

- ❑ **I was given the opportunity to read, have read or had explained to me Dunbar Eye Associates, PLLC's Notice of Privacy Practice prior to any services offered.**
- ❑ **The Notice of Privacy Practice could not be read due to the emergent nature of the care and will be acquired when possible**

I authorize Dunbar Eye Associates, PLLC, to release my personal health information to the following individuals:

_____ _____

My vision plan requests that all diagnoses related to any medical condition I may have be released to them. As a non-traditional disclosure, release of this information requires my specific authorization:

- ❑ **I authorize the release of medical information to my vision plan**
- ❑ **I do not authorize release of medical information to my vision plan**

Our office may use standard email to communicate with you. Standard email is not secure and does not guarantee privacy.

- ❑ **I authorize the use of standard email, in spite of the known risk involved, to communicate with me.**
- ❑ **I do not authorize the use of standard email to communicate with me.**

I have read and understand this form. I am signing it voluntarily. If you are signing as a personal representative of the patient, please indicate your relationship. If you are signing for a minor, you attest that you have legal authority to make medical decisions for the minor.

Patient Signature	Date
Representative Signature	Relationship to Patient