WESTMINSTER VISION ASSOCIATES

Notice of Privacy Practices Receipt

Our Notice of Privacy Practices provides information on how our practice may use and/or disclose protected health information about you for treatment, payment and health care operations. A copy of our NPP can be found at the check-in desk or at www.westminstervision.com.

Patient's Name (Print): _____

Patient's Date of Birth: _____

I authorize the following people to have access to my health information:

Name/Relationship to Patient: _____

Name/Relationship to Patient: _____

Name/Relationship to Patient: _____

I understand that I have a right to revoke this authorization at any time and that I have the right to copy or inspect the privacy practices I have provided. Written documentation will be provided to change any of this information. Also, I understand that I have the right to refuse to sign this authorization and that my services will not be conditioned upon. This information shall be in effect until revoked by me.

Patient Name (Print):_____

Signature of Patient/Legal Guardian: _____

Date: _____