Acknowledgement Of Consent

By signing this form (see bottom) I acknowledge and agree as follows:
-A copy of **Jordan Family Eyecare's** privacy practices has been offered to me prior to signing this consent.
-**Jordan Family Eyecare** reserves the right to change its privacy practices in accordance with applicable law.
-I understand that, and consent to, the following appointment reminders that will be used by the practice. Please initial all that you approve.

- _____A postcard mailed to me at the address provided by me
- _____Texting (_____)_____________Telephoning (_____)_____________
- _____ Leaving a message on my answering machine
- _____Leaving a message with the individual answering the phone
- _____Email sent to______________________________@____________.com

Patient Disclosure Form

In regards to minors:
Please print parent(s) or guardian(s) name (including yourself) and relationship to patient as well as any other parties you would like medical information to be released to:

Name:____ Relationship:_____________

Name:____ Relationship:_____________

Name:____ Relationship:_____________

In regards to adults:
Please list any parties you would like medical information to be released to:

Name:____ Relationship:_____________

Name:____ Relationship:_____________

Name:____ Relationship:_____________

- _____I decline the disclosure of my medical records to any person(s)

This disclosure shall remain in effect until an updated form is obtained revoking this authorization

Patient Name:___________________________________ Date:_________________

Signature:____

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