Rockrimmon Vision Source
6005 Delmonico Drive, Suite 140, Colorado Springs, CO 80919
Ph: 719-522-9393 | Fax: 719-532-1114

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received the ***Notice of Privacy Practices*** from Rockrimmon Vision Source. I have read the document and I understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment, and healthcare operations.

Patient Name:_____

Signature:_____ Date:_____

***If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form:**

Relationship to Patient:_____ Print Name:_____

Source of Authority: _____

AUTHORIZATION TO RELEASE PERSONAL INFORMATION

Many of our patients allow family members such as their spouse, significant other, parents or children to call and request the result of tests, procedures, and financial information. Under the requirements of our Privacy Practices, we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical information, any diagnostic test results and/or financial information released to any family members you must sign this form. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize Rockrimmon Vision Source to release my records and any information requested to the following individuals.

1. _____ Relation to Patient:_____
2. _____ Relation to Patient:_____
3. _____ Relation to Patient:_____
4. _____ Relation to Patient:_____

Authorization Regarding Messages (please check all that apply)
____ I authorize you to leave a detailed message on my home or cell number regarding appointments
____ I authorize you to leave a detailed message on my home or cell number regarding medical treatment, care, test results or financial information
____ I authorize you to leave a message with anyone who answers the phone
____ Messages may only be left with:_____

Signature:_____ Date:_____

***Note: this does not replace a Medical Release Form. A Medical Release Form will still need to be filled out to send or receive any medical exams, procedures, tests, etc. from other medical offices.**