Alderwood
Vision Therapy Center, PLLC
TRANSFORMING LIVES THROUGH VISION

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NOTICE OF HIPAA PRIVACY PRACTICES, RELEASE OF INFORMATION & ENCRYPTED EMAIL COMMUNICATIONS

ACKNOWLEDGEMENT OF HIPAA PRIVACY PRACTICES

I acknowledge that I have been offered a copy of *Alderwood Vision Therapy Center, PLLC's* Notice of Privacy Practices. The Statement of Privacy Practices describes the types of uses and disclosures of my protected healthcare information (PHI) that might occur in my treatment, payment for services or in the performance of office health care operations. It also describes my rights and responsibilities and the duties of this office with respect to my PHI. The Statement of Privacy Practices is also posted in the office.

RELEASE OF INFORMATION

In addition to the allowable disclosures described above in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my PHI to the following person(s) indicated below. I understand that I may revoke my decision at any time and that it must be done by me, in writing directly, to *Alderwood Vision Therapy Center, PLLC.*

☐ No one

☐ Family member, (full name and relation): _____

☐ Spouse/significant other, (full name):_____

ENCRYPTED EMAIL AUTHORIZATION

I hereby authorize *Alderwood Vision Therapy Center* to transmit my PHI relating to my treatment, health and payment history via encrypted email. I approve this information to be emailed directly to me or someone I designate listed below. I also authorize my PHI to be emailed to other healthcare providers, health plans and any other party involved in my treatment and payment for my treatment. I understand that the PHI that will be emailed may include, but is not limited to, my health history, diagnosis, treatment plans and payment records. I understand that I may revoke my decision at any time and that it must be done by me, in writing, directly to *Alderwood Vision Therapy Center, PLLC.*

Email Address: _____

- o Decline

Date _____

Patient name _____ **Signature** _____