SHEPARD AND QUINTON VISION CARE

Notice and Acknowledgement of Privacy Practices (HIPAA)

1. Acknowledgement

I acknowledge that I have received a copy of Shepard & Quinton Vision Care's / Denise Q. Shepard, OD Notice of Privacy Practices.

_____ _____

Patient/Guardian/Personal Representative Date

2. Request for Restrictions on Use of Your Protected Health Information

_____

_____

_____

3. Request for Communication by Alternative Means

_____

_____

_____

May we send you information about our practice?

Yes ☐ **No** ☐

May we send you appointment reminders?

Yes ☐ **No** ☐

_____ _____

Patient/Guardian/Personal Representative Date