VISION SOURCE®

ACKNOWLEDGEMENT
OF
NOTICE OF PRIVACY PRACTICES

The law requires that David G. Chandler, OD make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that (please check any/all that apply to you) :

- ☐ I have read or had explained to me David G. Chandler, OD's Notice of Privacy Practice and agree to continue my care with David G. Chandler, OD under said terms.
- ☐ I was given to opportunity to read David G. Chandler, OD's Notice of Privacy Practices and declined but wish to continue my care with David G. Chandler, OD under the terms of David G. Chandler, OD's privacy policies.
- ☐ I have read or had explained to me David G. Chandler, OD's Notice of Privacy Practice and do not wish to continue my care with David G. Chandler, OD under said terms.
- ☐ The Notice of Privacy Practice could not be read due to the emergent nature of the care of other reason described as

  _____
  _____

- ☐ I understand that standard email and text communication may not be totally secure. I still consent to communications from my doctor or staff through my standard email and texting devices.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

_____ _____
Patient Date

If you are signing as a personal representative of the patient, please indicate your relationship

_____ _____
Representative Relationship to Patient