vista medical associates

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name Date of Birth

I hereby acknowledge that I have received /reviewed Vista Medical Associates' Notice of Privacy Practices. A copy of the most recent Privacy Notice is available online at www.vistamedcare.com/download/privacy-policy/ and is available on request.

☐ By checking this box, you agree to receive TEXT messages from Vista Medical Associates related to scheduling, appointments, follow ups, results and orders. You may reply STOP to opt-out at any time. For Assistance, reply HELP. Messages and data rates may apply. Message frequency will vary. Please review our privacy policy and terms of service.

_____ _____

PATIENT NAME (please print) PATIENT DATE OF BIRTH

_____ _____

PATIENT/GUARDIAN SIGNATURE DATE

_____ _____

PATIENT PHONE XXX-XXX-XXXX NAME OF PHYSICIAN

If not signed by the patient, please indicate relationship:

- ☐ Parent or guardian of minor patient
- ☐ Guardian or conservator of an incompetent patient
- ☐ Beneficiary or personal representative of deceased patient

PERMISSION TO DISCUSS PROTECTED HEALTH INFORMATION WITH OTHERS

I hereby grant permission to Vista Medical Associates to speak to the following individuals about my health and disclose my health information including billing and insurance. I understand this authorization does not include information regarding HIV, psychiatric, drug and/or alcohol records, which must be authorized on a separate release.

	NAME	DOB
Spouse	_____	_____
Children	_____	_____
	_____	_____
	_____	_____
Guardian	_____	_____
Caregiver	_____	_____
Sister	_____	_____
Brother	_____	_____
Friend	_____	_____
Emergency Contact	_____	_____
Other	_____	_____

You may discuss my (please check all that apply)

Visit Notes Laboratory Results X-rays Reports All Services and Treatment Rendered

I understand that I may revoke this authorization at any time in writing.

Patient Name (please print)_____ Patient Date of Birth_____

Patient/Guardian Signature_____ Date _____