Acknowledgment of Notice of Privacy Practices 6/1/26

Hole Family Eyecare/Grand Teton Eye & Optical
110 Buffalo Way, Ste. A Jackson, WY 83002 307-733-4905

____I read or was given the opportunity to read Grand Teton Eye & Optical's Notice of Privacy Practices prior to any services offered.

____ The Notice of Privacy Practices could not be read due to the emergent nature of the care and will be acquired when possible.

I authorize Hole Family Eyecare to release my personal health information to the following individuals:

Name:	Relationship:	Phone Number:
_____	_____	_____
_____	_____	_____

Our office may use texts and emails to communicate with you. These texts or emails may not be encrypted and therefore complete privacy cannot be guaranteed.

___ I authorize the use of unsecured text and email ___ I do not authorize the use of unsecured text and email to communicate with me

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

_____ / _____

Patient Signature / Date

Minor/Personal Representative:

If you are signing as a personal representative of the patient, please indicate your relationship. If you are signing a minor, you attest that you have the legal authority to make medical decisions for the minor and consent to such care. Please indicate any other parent, step-parent, guardian or other individual(s) authorized to make medical decisions for the minor.

_____ / _____

Representative Signature / Relationship to Patient

Other individuals authorized to make legal decisions for the minor