Acknowledgment of Notice of Privacy Practices

Michael M. Monson OD PC/ dba BUTTE FAMILY EYE CENTER
1221 Dewey Blvd. Butte MT 59701
406-494-2222

The law requires that Michael M. Monson OD PC make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

____I was given the opportunity to read, have read or had explained to me Michael M. Monson OD PC's Notice of Privacy Practice prior to any services offered.

___ The Notice of Privacy Practice could not be read due to the emergent nature of the care and will be acquired when possible

I authorize Michael M. Monson OD PC to release my personal health information to the following individuals:

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

____
Printed Name

____ ______________________
Patient Signature Date

If you are signing as a personal representative of the patient, please indicate your relationship. If you are signing for a minor, you attest that you have legal authority to make medical decisions for the minor.

____ ______________________________
Representative Signature Relationship to Patient