Dr. Craig B. Pruitt, O.D.
Vision Plus LLC
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Notice of Privacy Practices
COPY GIVEN UPON REQUEST

Signing this document signifies that you have a right to receive a copy of our Notice of Privacy Practices

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct healthcare operations involving our office. The Notice of Privacy Practices describe these uses and disclosures in detail.

I acknowledge that I have been made aware of the Notice of Privacy Practices by Vision Plus.

______________________________ ____________________
Patient's Signature or Parent/Guardian if Minor **Date**

If signing as a personal representative of the patient, describe the relationship to the Patient and the source of authority to sign this form:

______________________________ ____________________
Relationship to Patient **Print Name**

Source of Authority:______________________________