DR. BLACK OPTOMETRY
PROFESSIONAL CORPORATION

Patient Privacy Protection Form

NOTE TO PATIENT: We want your informed consent. This means that we want you to understand the services we will provide to you and what we do with personal information we obtain about you. If you have a question on any of this, please ask.

CONSENT FOR PERSONAL INFORMATION
I understand that to provide me with optometric/ optical services and products this practice will collect some personal information about me (e.g. home telephone number, address, health number, medication used and so on).

I have reviewed this practice's Privacy Policy with respect to the collection, use and disclosure of personal information, steps taken to protect the information and my right to review my personal information. I understand how the Privacy Policy applies to me. I have been given a chance to ask any questions I have about the Privacy Policy and they have been answered to my satisfaction.

I understand that I may receive without request, some of the following notices and information via telephone, e-mail or post. If I do not want to receive some of this information, I agree to advise the practice of my refusal in writing.

[ ] Notice of when it is time to review my eye and vision care needs including reminder notices for another eye exam.
[ ] Newsletters and other informational mailings from this practice.
[ ] Notice of promotions and special offers from this practice.
[ ] Notice of promotions and special offers from other organizations that this practice understands might be of interest to me.
[ ] Information relevant to my medical condition.

I understand that, as explained in the Privacy Policy, there are some rare exceptions to these commitments.

I agree to this practice collecting, using and disclosing personal information about me as set out above and in this practice's Privacy Policy.

SIGNATURE:_____ DATE:_____

NAME:_____

NOTES MADE BY DR. BLACK OPTOMETRY

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