LONG VISION CENTER
Clint A. Long, Eye M.D.

I understand that my health information is protected and the protection is described by a document entitled Notice of Privacy Practices. Simply by asking, I will be provided access to this document. Protected health information (PHI) may be used to carry out treatment, payment, or health care operations. It is my right to restrict the use and disclosure of my PHI. My doctor is not required to agree to these restrictions.

I hereby acknowledge that Long Vision Center's Notice of Privacy Practices was made available to me if desired.

Print Patient's Name: _____ Date: _____

Authorizing Signature: _____ Date: _____

List anyone we are authorized to discuss your PHI with (family, friends, and caretakers):

_____ _____

_____ _____