INSIGHT
VISION CENTER

615 S. Caelin Springs Road, #404 | Arlington, Virginia 22204 | (703) 931-1013

6128 Brandon Avenue, Suite 201 | Springfield, VA 22150 | (703) 750 2020

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

Please fill out the section below to authorize Insight Vision Center PLLC to release your medical information for purposes other than treatment, payment, or healthcare operations.

__Do not disclose my medical information.

__You may disclose the following medical information:

__Appointment Information __Test Results __Medications __All Information

Please release my information to:

Name: _____ Relation to Patient: _____

Name: _____ Relation to Patient: _____

I acknowledge the receipt of the Notice of Privacy Practices given to me by Insight Vision Center PLLC. (Francis DiPaolo, M.D.)

_____ _____
Signature of Patient or Legal Representative Date

Relationship to Patient (if signed by legal representative): _____

FOR OFFICE USE ONLY: Reason why acknowledgment could not be obtained:

__Patient refused to sign. __ Emergency situation. __Other

Please explain:_____

Employee signature:_____ Date:_____