HIPAA

By signing below I acknowledge that I have been offered a copy of Peninsula Vision Care's Notice of Privacy Policy. I authorize Peninsula Vision Care to share information about my medical records with the following person(s). I understand that this information may be shared in oral or written form. I also understand that I may revoke this authorization in writing at any time.

_____	_____
Patient/ Legal Guardian or Representative	Date
_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Name	Relationship

Consent to Receive Text Messages and/or Emails from Peninsula Vision Care

By signing below, I authorize Peninsula Vision Care through its vendor Solution Reach to contact me by SMS text message or email. Peninsula Vision Care will send me text messages or emails for improved communication and patient care, for reasons including but not limited to:

- Appointment reminders
- Notifications that materials are in
- Payment due reminders
- Contact lens reordering reminders
- Information about sales or events
- Information about our office, products, or services

I understand that message/data rates may apply to messages sent by Peninsula Vision Care to my cell phone. I know that I am under no obligation to authorize Peninsula Vision Care to send me text messages or emails. I may opt-out of receiving these communications from Peninsula Vision Care at any time by calling them @ (920)743-5053 or by texting 'STOP' to the message received.

Patient/ Legal Guardian Signature: _____

Date: _____