Notice of Privacy Practices
Patient Acknowledgement

I have received Southeastern Retina Specialists' Notice of Privacy Practices written in plain language. This notice provides, in great detail, the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice on request.

Signing this acknowledgement does not mean that you have agreed to any special uses or disclosures of your health records. Refusing to sign the acknowledgment does not prevent the practice from using or disclosing health information as the Rule permits it to do. If you refuse to sign this acknowledgment, the practice must keep a records that they failed to obtain your acknowledgement.

_____ _____

Patient Signature Date Signed

Relationship to patient: _____
(If signed by a personal representative of patient)

Patient Name: _____ DOB: _____