Retina Center Of Pensacola

Acknowledgement of Receipt of Notice of Privacy Practices

I understand and have been provided with a Notice of Health Information Privacy Practices, which provides a complete description of health information uses and disclosures. I understand that I have the following rights and privileges.

- The right to review the notice prior to signing this consent
- The right to object to the use of my health information for directory purposes
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations

I understand that I may revoke my consent for the use of my health information in writing at any time. I also understand that if I revoke my permission, Retina Center of Pensacola will no longer use or disclose medical information about me for the reasons covered by my written authorization.

I understand that Retina Center of Pensacola is unable to take back any disclosures already made with my permission, and that they are required to retain the records of care provided to me. I further understand that if I choose to revoke my consent, Retina Center of Pensacola may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

By signing this document, I acknowledge that I have been provided with a copy of this office's Notice of Privacy Practices.

Print Name Signature Date

_____ _____ _____

Office Use Only

Date Acknowledgement received _____ by _____

OR reason acknowledgement was not obtained _____