



Acknowledgement Form Notice of Privacy Practices

Effective April 14, 2003

This Acknowledgement Form is provided to you as required by the Privacy Rule and Related Regulations under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA")

You are asked to sign this form so that we can confirm that you have received it. Your signature only confirms that you received this form. Your signature does not mean that you agree with any of the policies and procedures outlined herein.

You may refuse to sign this Acknowledgement Form, at which time our staff is required to document the date and time of your refusal, as well as your reason for not signing.

I acknowledge receipt of a copy the The Retina Institute Notice of Privacy Practices, as of the date indicated below.

Name of Patient (PRINT)

Account #

Signature of Patient

Date Signed

If checked, please see Page 2 for Patient's Refusal to sign