Kevin J. Blinder, MD
Sabin Dang, MD
Alia K. Durrani, MD
Nicholas E. Engelbrecht, MD
Avinash V. Honasoge, MD, PhD

THE RETINA INSTITUTE

Daniel P. Joseph, MD, PhD
Thomas K. Krummenacher, MD
Athanasios Papakostas, MD
Gaurav K. Shah, MD
Bradley T. Smith, MD

Administrative Office: 2201 S. BRENTWOOD BLVD. / ST. LOUIS, MISSOURI 63144 / 314.367.1181 or 800.888.0011 / fax: 314.968.3375 / TRI-STL.com

Acknowledgement Form: Notice of Privacy Practices

Patient Name: ______________________________ Date of Birth: ______________

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").

If you like a copy of our HIPAA policy, please ask the receptionist, or you may also review it on our website at TRI-STL.com ("Patients" menu - "Forms" section).

I acknowledge that I have been offered a copy the The Retina Institute Notice of Privacy Practices, as of the date indicated below.

Authorization of Communication to Designee(s)

By signing below, I approve access to my Personal Health Information (PHI).

Designee Name: ____________________________ Relationship: ______________

Phone Number: ______________________ ☐ Cell ☐ Home ☐ Work ☐ Other

---

Designee Name: ____________________________ Relationship: ______________

Phone Number: ______________________ ☐ Cell ☐ Home ☐ Work ☐ Other

---

I understand that I may revoke this authorization at any time through written notice.

Signature: ________________________________ Today's Date: ______________
(Patient, Parent, or Legal Guardian)