Acknowledgement of Notice of Privacy Practices

("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used for the purposes of conducting and coordinating care, obtaining payment, and supporting health care operations of Apex Retina Institute. I acknowledge that I have received the Notice of Privacy Practices, which provides a comprehensive explanation of how my protected health information may be used or disclosed. I was given the opportunity to review the notice prior to signing this consent.

I understand that Apex Retina Institute has the right to change its Notice of Privacy Practices from time to time, and that I may contact this organization at any time to obtain the most current copy of the Notice of Private Practices.

I understand that I may request in writing restrictions on the use or disclosure of my protected health information. I also understand that Apex Retina Institute is not required to agree to my requested restrictions, but are bound to abide by such restrictions upon agreement.

I understand that I may revoke my consent to use and disclose my protected health information upon written request. Any use or disclosure that has already occurred prior to the date the revocation request is received will not be affected.

As per HIPAA, Apex Retina Institute reserves the right to decline service if the consent form is not signed.

I HAVE READ AND UNDERSTAND THIS CONSENT. I CONSENT TO THE USE AND DISCLOSURE OF MY HEALTH INFORMATION IN ACCORDANCE TO THE NOTICE OF PRIVACY PRACTICES.

Name of Patient (Please Print) _____

Signature of Patient Date _____

Signature of Patient Representative _____

Relationship of Patient Representative to Patient _____

Date _____