Retina Consultants of SOUTHERN CALIFORNIA

Notice of Privacy Practices Patient Acknowledgement

Patient Name: _____

Date of Birth: _____

The Retina Consultants of Southern California *Notice of Privacy Practices* provides detailed information about how we may use and disclose your protected health information.It also describes your right to request restrictions on how we may use and disclose this information.

Our *Notice of Privacy Practices* can be accessed at ***www.retinasc.com***. Additional copies may also be obtained by contacting our office at (951) 788-0222.

By signing below, I acknowledge that I understand that Retina Consultants reserves the right to change the terms of this notice, *Notice of Privacy Practices* and to make changes regarding all protected health information controlled by this practice. If changes to the policy occur, Retina Consultants will provide a revised copy upon request.

Signature: _____
(Patient/Parent/Conservator/Guardian)

Date: _____ Relationship to patient: _____