PA RETINA SPECIALISTS, P.C.

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

Regulations require that we make a "Good Faith" effort to provide you with a copy of our Privacy Notice. You are not required to accept the Notice.

I acknowledge that I received or had the opportunity to review The Notice of Privacy Practices for PA Retina Specialists, P.C.

In order to comply with federal regulations regarding your privacy in our office, we ask that you complete the following questions:

I consent to leaving appointment message on:

- **Home Phone (incl. Auto Call) Y N**
- **Cell Phone (incl. Auto Call) Y N**
- **Send Via Mail Y N**

Leave other medical information on:

- **Home Phone Y N**
- **Cell Phone Y N**
- **Send Via Mail Y N**

Leave appointment message with and/or share patient information with another person? Y N

If you answered YES to allowing us to discuss your appointment and/or medical information with another person, please list their name(s), relationship(s), and phone # below:

NAME	RELATIONSHIP	HOME PHONE #	CELL PHONE #
_____	_____	(____)_____ - _____	(____)_____ - _____
_____	_____	(____)_____ - _____	(____)_____ - _____
_____	_____	(____)_____ - _____	(____)_____ - _____

HIPAA Contact Special Instructions: _____

_____
Name of Patient

_____ _____
Signature of Patient **Date**
(or patient's personal representative)

Personal representative information (if applicable – Family Member or POA)

_____ _____
Name of Patient Representative **Relationship to Patient**

POA Papers Provided Y N