PATIENT ACKNOWLEDGMENT OF
HIPAA NOTICE OF PRIVACY PRACTICES

Dear Patient,

The Retina Group of Northeast Ohio, Inc. is committed to maintaining the integrity of your protected health information and complies with all applicable state and federal regulations. In support of this commitment, the Retina Group of Northeast Ohio, Inc. provides patients with a Notice of Privacy Practices pursuant to the Health Insurance Portability and Accountability Act ("HIPAA"). You are entitled to receive a copy of the Notice of Privacy Practices in paper format or electronic format, whether you sign this Acknowledgment or not.

Receipt of HIPAA Notice of Privacy Practices

I acknowledge receipt of the Notice of Privacy Practices with detailed information about how the Retina Group of Northeast Ohio, Inc. may use and disclose my protected health information. I understand that the Retina Group of Northeast Ohio, Inc. reserves the right to change the privacy notice and that a copy of the revised notice will be made available to me.

_____ _____
Patient Name (Please Print)

_____ _____
Patient Signature Date

OR

_____
Printed Name of Personal Representative

Authority of Personal Representative to Sign for Patient (check one):

☐ Parent ☐ Legal Guardian ☐ Power of Attorney ☐ Other: _____

_____ _____
Signature of Personal Representative Date

Office Use Only: To be completed only when a patient declines to sign acknowledgment.

Check here if patient declined to sign acknowledgment _____

Privacy Official signature: _____ Date: ____/____/____

Refusal to sign acknowledgment does not prevent the patient from continuing to be treated.

To be filed in patient's record