RETINA ASSOCIATES OF KENTUCKY

PRIVACY CONSENT

For Purposes of

Treatment, Payment and Healthcare Operations

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. Each patient must read our Notice of Privacy Practices and return their signed acknowledgment of their receipt. This acknowledgement must be filed in the patient's chart.

I hereby consent to Retina Associates of Kentucky, my health care provider, using or disclosing my protected health information for the purpose of providing health care treatment to me, obtaining payment for health care services rendered to me or to carry out the Practice's health care operations.

The full Notice of Privacy Practices provides a more detailed description of the uses and disclosures allowed by this consent. I acknowledge a copy of the Notice of Privacy Practices has been made available to me. I understand the Practice reserves the right to change the privacy practices and that I can obtain a revised copy of the notice at the front desk.

I understand that I can request restrictions on the way my health care information is used and disclosed, but I also understand that the Practice is not required to agree to any of my restrictions, but if it does, the restriction is binding on the Practice.

OPTIONAL:
I give permission to discuss my medical information with the specific individuals listed below:
Please print name and relationship to patient.

1. _____ 2. _____

3. _____ 4. _____

This authorization will remain in effect until written notice of revocation is received. I understand that I can revoke this consent in writing, at any time, but that this revocation will not apply to uses of my records between the date of this consent and the date of revocation.

_____ _____
Patient Name (Print) Date

_____ _____
Signature of Patient, Parent, or POA Witness Signature

For Office Use Only:

_____ Retina Associates of Kentucky made a **"*good faith*"** effort to obtain the individual's acknowledgement of the Notice of Privacy Practice.

_____ _____
Signature of Practice Representative Date