PATIENT'S ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I hereby acknowledge that I received the Medical Information Privacy Policy Notice from Dr. Ali Tabassian, Dr. Juan Astruc, Jr., or Dr. Stewart O'Keefe for my review prior to receiving services through the Retina Institute of Virginia.

PERMISSION TO DISCUSS PHI

I hereby give Retina Institute of Virginia limited permission to disclose to a family member, other relative or close personal friend, or any other person identified by me, the protected health information directly related to such person's involvement with my care or payment related to my health care.

NAME	RELATIONSHIP	INFORMATION			
		Treatment	Billing	Appointments	All

Print Patient Name **Patient Signature** **Date**

I, _____ (Print representative's Name), am signing this Limited Permission on behalf of the patient set forth above. My authority to sign this Limited Permission and agree to the terms herein exists because I am _____ (describe authorization of Representative).