Retina Associates of South Texas, P. A.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____ acknowledge that I have received
(Name of Patient)

a notice of **Retina Associates of South Texas, P.A.'s** Notice of Privacy Practices. This notice describes how **Retina Associates of South Texas, P.A.** may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information and rights I may have regarding my protected health information.

_____

(Signature of Patient or Personal Representative) *(Date)*

_____

(Relationship to Patient)