



I have been given the opportunity to read the Florida Retina Institute's Notice of Privacy Policy concerning how my personal information may be used. I give my permission to use my personal information in accordance with this policy. This signature sheet will remain in the patient's chart as record of acceptance and the Notice of Privacy Practice is for the patient (or patient's representative) to keep his/her records.

Patient's Name: _____

SIGNATURE (Patient or Authorized Representative): _____

Relationship to Patient if other than self: _____

Date: _____

* You may receive a copy of Florida Retina Institute's Notice of Privacy Policy upon request at check-in. Thank You.