ACKNOWLEDGEMENT OF RECEIPT
OF NOTICE OF PRIVACY PRACTICES
FOR THE RETINA CENTER OF CHARLESTON, P.A.

I, ________________________, hereby acknowledge that I have been offered
Print patient name

and received or declined a copy of the **Retina Center of Charleston, P.A.** Notice of Privacy Practices.

I, _________________________, understand that I have the option to access my
Print patient name
chart/records from **The Retina Center of Charleston, P.A.** by requesting a login and password from the office and accessing: **https://www.mypatient.com**

I, ________________________, acknowledge and agree that **The Retina Center**
Print patient name
of Charleston, P.A. may disclose my protected health information to my personal representative(s) and that my personal representative(s) has the authority to authorize the practice to use and disclose my protected health information. I designate the following individual(s) as my personal representative(s) for purposes of all rights, obligation, and responsibilities created under the **HIPAA Privacy Rules**.

1)________________________________ ________________ ____________________
Name Relationship Phone #

2)________________________________ ________________ ____________________
Name Relationship Phone #

3)________________________________ ________________ ____________________
Name Relationship Phone #

________________________________ ________________________________
Signature of Patient **Date**

________________________________ ________________________________
Signature of patient representative **Relationship to patient**
(only if patient is unable to sign)