ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge receipt of the *Notice of Privacy Practices* of Southern Vitreoretinal Associates, P.L. The *Notice* provides information about how we may use and disclose your medical information and how you can get access to this information. We encourage you to read it in full. The *Notice* is subject to change. If you have any questions about the *Notice*, please contact our Privacy Officer at 850/942-6700.

Firearms and Video/Audio recording are strictly prohibited on our premises.

I acknowledge receipt of the *Notice*.

Patient Name:_____

Signature:_____ Date:_____

If signer is not the Patient:

Signer's Name:_____

Relationship to Patient:_____

OFFICE USE ONLY: To be completed by provided representative if signed Acknowledgment is not obtained.

Representative Name: _____ Initials: _____

Date:_____

Description of efforts made to obtain Acknowledgment and reasons why not obtained:

_____

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