RETINA
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DISEASES OF THE RETINA
MACULA AND VITREOUS

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Privacy Notice
(Acknowledgement of Receipt)

I have been presented with a copy of Retina Associates, P.A. Privacy Notice detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Privacy Notice.

Red Flag Rule

I also understand a "Red Flag Rule" policy has been put in place to protect my information against identity theft. I have been informed that a copy of the Red Flag policy can be obtained at 9800 Baptist Health Drive, Ste. 200, Little Rock, AR 72205

I request the following restriction(s) concerning the use of personal medical information.

_____

_____

Further, I permit a copy of this acknowledgement with or without restrictions to be placed in my medical record.

Signed:_____Date:_____

Authorization of Release of Medical or Financial Information

Please list below any person(s) in addition to your referring physician and their practice or your insurance company that you are authorizing to receive or discuss medical records or financial information regarding your visits with our practice.

Name	Relationship to Patient

Cell Phone Acknowledgement

Our physicians have asked that each patient; family member(s), caregiver(s), or transportation service providers turn all cell phones **off** during their visit at our office except while in patient reception areas. We appreciate your cooperation regarding this matter.