

**PATIENT CONSENT FORM AND ACKNOWLEDGMENT  
FOR NOTICE OF PRIVACY PRACTICES**

Retina Associates of Utah's written Notice of Privacy Practices provides detailed information on how they may use and disclose my protected health information. By signing this form, I acknowledge that I have received the Notice of Privacy Practices and am in agreement with their use and disclosure of my protected health information for treatment, payment and operations of the practice.

I understand that I may request, in writing, restrictions to the use or disclosure of my protected health record, and that I am able to provide access to my personal health information by written authorization as specified in Retina Associates of Utah's Notice of Privacy Practices. I also understand that Retina Associates of Utah may charge a fee for the costs of copying, mailing and supplies associated with any request for copies of my health information.

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Printed Name

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Date of Birth

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Signature of Patient or Authorized Representative Date