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

I, _____, hereby acknowledge that I have received a
Print patient name
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://app.wellcentive.com/DrFirst/**

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 (only if patient is unable to sign) **Relationship to patient**