VIRGINIA RETINA CENTER

Notice of Privacy Practices Form

THIS NOTICE DESCRIBES HOW MEDICAL/PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

SUMMARY:

By law, we are required to provide you with our Notice of Privacy Practices (NPP). This notice describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information.

As a patient, you have the following rights:

1. The right to inspect and copy your information.
2. The right to request corrections to your information.
3. The right to request that your information be restricted.
4. The right to request confidential communications.
5. The right to a report of disclosures of your information, and
6. The right to a paper copy of this Notice.

We want to assure you that your medical/protected health information is secure with us. This Notice contains information about how we will insure that your information remains private.

If you have any questions about this Notice, the name and phone number of our contact person is listed on this page.

Effective Date of this Notice	September 20, 2004
Contact Person	Joanne DeBoer
Phone Number	703-443-0015

Acknowledgement of Notice of Privacy Practices

I hereby acknowledge that I have received a copy of the practice's NOTICE OF PRIVACY PRACTICE, I understand that if I have questions or complaints regarding my privacy rights that I may contact the person listed above. I further understand that the practice will offer me updates to this NOTICE OF PRIVACY PRACTICES should it be amended, modified, or changed in any way.

I understand that I have the right to request restrictions on the use or disclosure of my individually identifiable health information to carry out treatment, payment, or health care operations. I further understand that Virginia Retina Center is not required to agree to the requested restriction but that, if it does agree, it must honor the restriction unless I request that it stop doing so or Virginia Retina Center notifies me that it is no longer going to honor the request. *I request the following restrictions on the use or disclosure of my individually identifiable health information:*

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I understand that I have the right to request restriction as to the method of communications to me. For example, I might request that all medical bills be mailed to a certain post office box rather than to my home. I further understand that Virginia Retina Center must honor this request if the *method of communication* is reasonable. Virginia Retina Center may not ask me why I want the alternate method of communication.

_____ _____

Patient or Representative Name (please print) Date

_____ _____

Patient or Representative Signature Date

□ Patient Refused to sign □ Patient was unable to sign because:

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