

Piedmont Retina Specialists

Patient Authorization for Use and Disclosure of Protected Health Information

By signing, I authorize Piedmont Retina Specialists to use and/or disclose certain protected health information (PHI) about me to (enter the name of the person(s) with whom we may share your PHI). _____

Signature: _____

Acknowledgement of Receipt of Privacy Policies and Red Flags Rule

By signing, I acknowledge that I have received a copy of Piedmont Retina Specialists Patient Privacy Notice and Red Flags Rule in the office. Upon my request, I may keep a copy the Notice/Rule. By signing the below I am also confirming that all information provided to Piedmont Retina Specialists, PA is true and correct.

Signature: _____

Statement of Patient Financial Responsibility

By signing, I acknowledge that I have read and agree to the Statement of Financial Responsibility.

Signature: _____

Printed Name: _____

If signed by someone other than the patient, the relationship to the patient is:

Date: _____ This authorization expires six months from today.