

VITREORETINAL CONSULTANTS

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NOTICE OF PRIVACY PRACTICES

I have reviewed the Vitreoretinal Consultants' Notice of Privacy Practices, which explains how my medical information will be used and disclosed.

Signature

Date

Patient's name-Printed

THE FOLLOWING SECTION IS TO BE COMPLETED IF APPLICABLE:

On behalf of the patient listed below, I have received a copy of Vitreoretinal Consultants' Notice of Privacy Practices, which explains how the patient's medical information will be used and disclosed.

I am authorized to sign on the patients' behalf in the capacity of (check one):

_____ Legal guardian (documentation required)

_____ Power of Attorney (documentation required)

_____ Parent of a minor