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Silver Spring, MD 20902

## Notice of Privacy Practice Signature Sheet

I have read and understand the DC Retina / Neal Adams MC PC's Notice of Privacy Practice on how DC Retina / Neal Adams MD PC will use my personal information. I give my permission for my personal information to be used in that manner. This signature sheet will remain in my patient chart as a record of acceptance and the Notice of Privacy Practice is for me or my representative to keep for my records.

Patient Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Name of Person (if other than patient): \_\_\_\_\_

Relationship to Patient (if other than self): \_\_\_\_\_

Date: \_\_\_\_\_