

**ROBERT J. KRAUT, M.D.**

**FLORIDA RETINA AND VITREOUS CENTER, P.A.**

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**PATIENT NOTICE OF PRIVACY PRACTICES**

This notice summarizes how medical information about you may be used and disclosed. The complete NOTICE OF PRIVACY PRACTICES of Florida Retina and Vitreous Center, P.A. is available in the waiting room for your review.

Florida Retina and Vitreous Center, P.A. will use your medical information for the following:

1. TREATMENT: Including providing your medical records to consulting clinicians and insurance companies.
2. PAYMENT: We will file necessary claims to insurance companies in your name to obtain payment. They may request part or all of your medical record to pay the claim.
3. HEALTH CARE OPTIONS: Any others involved in your healthcare.

To protect your privacy and in conjunction with our policy please provide us with the following information and authorizations:

1. Name of person or persons we may speak to regarding your health (i.e. spouse, child, etc.)

_____	_____
Name	Phone number
_____	_____
Name	Phone number
_____	_____
Name	Phone number

2. May we leave a message regarding your health or an upcoming appointment on your answering machine? YES \_\_\_\_\_ NO \_\_\_\_\_
3. I acknowledge that I have the opportunity to review a copy of Florida Retina and Vitreous Center, P.A.'s Notice of Privacy Practices with effective date of 4/14/03. Such copy being available in the waiting area.
4. I authorize the release of protected health information to my insurance company only to the extent necessary to obtain payment for services rendered.

**Signed:** \_\_\_\_\_ **Print Name:** \_\_\_\_\_

**Date:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Witness:** \_\_\_\_\_