montanaretina CONSULTANTS

MARK R. COMARATTA M.D.

PRACTICE LIMITED TO DISEASES OF THE RETINA - VITREOUS

Receipt of Notice of Privacy Practices
Written Acknowledgement Form

I, _____, have received a copy of MARK R. COMARATTA'S Notice of Privacy Practices.

AUTHORIZATION TO RELEASE INFORMATION

I give my permission to release information regarding my medical condition and treatment to the following non-medical persons:

Name: _____ Relationship: _____ Phone:_____

Name: _____ Relationship: _____ Phone:_____

Name: _____ Relationship: _____ Phone:_____

Name: _____ Relationship: _____ Phone:_____

_____ _____

Signature of Patient Date Signed