ADVANCED VEIN CENTER, LLC
NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA")
I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- **Conduct, plan and direct my treatment**
- **Follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.**
- **Obtain payment from third-party payers**
- **Conduct normal healthcare operations such as quality assessments and physician certifications**

I acknowledge that I have been offered/ and or received Advanced Vein Center's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that Advanced Vein Center has the right to change its Notice of Privacy Practices from time to time and that I may contact Advanced Vein Center at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name_____ Date of birth_____

Signature_____ Date_____

Patient Notification Form (HIPAA Policy)

Patient's Legal Name: _____Date of Birth: _____

Check One:

_____I do not want any information about my healthcare communicated to family members/caregivers.

_____I give Advanced Vein Center permission to verbally communicate to family members/caregivers listed:
_____

(check all that apply) ____Prescription Request ___Referral Request ___ Appointment Status

Cell# _____ Okay to leave message? Yes / No *Detailed message? Yes / No

Home# _____ Okay to leave message? Yes / No *Detailed message? Yes / No

Work#__ _____Okay to leave message? Yes / No *Detailed message? Yes / No

This authorization expires (12) twelve months from the date signed. I have the right to revoke this authorization in writing at any time. Revocation will not cover information/ material released prior to that date, but will prevent further release of information.

If you would like to grant permission to Advanced Vein Center to discuss AIDS/HIV, Alcohol and/ or Drug Abuse or Mental Health with anyone but yourself, please request a MEDICAL RELEASE FORM.

Patient Signature: _____Date:_____

Patient / Legal Guardian Signature: _____ Date:_____

*** Updated November 2015**