Associates in Vascular Care

Acknowledgment & Receipt of Notice of Privacy Practices- HIPAA

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent. You are also welcome to take a copy of the *HIPAA* privacy notice with you.

I am acknowledging that I have received the following HIPAA Notice of Privacy Practices. I also acknowledge and approve the uses and disclosures of my Protected Health Information (PHI) as described in the HIPAA Notice of Privacy Practices packet.

_____ _____

Signature of Patient or Representative *Date Signed*

□ *I do not agree with the above HIPAA Notice of Privacy Practices and therefore refuse to sign acknowledgement.*

_____ _____

Signature of Patient or Representative *Date Signed*