HIPAA Acknowledgement and Consent Form

I understand the Health Insurance Portability and 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 and follow-up care among the multiple healthcare providers who may be involved in that directly or indirectly.
- Obtain payment from designated third-party payers.
- Conduct normal health care operations such as quality assessments or evaluations and physician certifications.

I have been informed by DVVI of your Notice of Privacy Practices containing a more complete description of the users and disclosures of my health information (available in the office in print form). I have reviewed such Notice of Privacy Practices prior to signing this consent, and acknowledge that I have studied the Privacy Practices. I understand that this organization has the right to change its Notice of Privacy Practices from time to time, and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I,_____ give _____ permission to access to the following information.

__ Medical Records __ Reschedule Appointments __ Appointment Information __Financial

I authorize Desert Vein and Vascular Institute the following permissions (Check all that applies)

__ May leave a detailed message __ May leave a message with call back number only

__May not leave a message __ Other

If other selected, please specify below:

_____

I understand that I may revoke this consent in writing at any time except that the organization has taken action relying on this consent.

_____ _____
Patient's Name DOB: (mm/dd/yy)

_____ _____
Signed (Patient or Legal Representative) Date

_____
Legal Representative's Relationship to PT