Vein Associates of Texas

Notice of Privacy Practices and Patient Consent for Use and Disclosure of Protected Health Information

Patient Name:_____ Date:_____

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain Patient Rights regarding my health information.

I understand that Vein Associates of Texas may use or disclose my protected health information for treatment, payment, or health care operations-which means for providing health care to me, the patient; handling billing and payment; and taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

Vein Associates of Texas has a detailed document called the ***'Notice of Privacy Practices'***. It contains a more complete description of your right to privacy and how we may use and disclose protected health information.

I understand that I have the right to read the 'Notice' before signing this agreement. If I ask, Vein Associates of Texas will provide me with the most current ***Notice of Privacy Practices.***

My signature below indicates that I have been given the chance to review such copy of the ***Notice of Privacy Practices***. My signature means that I agree to allow Vein Associates of Texas to use and disclose my protected health information to carry out treatment, payment, and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that Vein Associates of Texas has taken action relying on this consent.

Signature:_____ (Patient or Legal Custodian/Authorized Representative)

Date:_____

Relationship to Patient if signed by another party:_____ Date:_____

You may obtain a copy of our *Notice of Privacy Practices,* including any revisions of our '*Notice'* at any time by contacting: Vein Associates of Texas 723 Hill Country Drive Suite C Kerrville, Texas 78028.