

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 (HIPPA), I have certain Patient Rights regarding my protected health information.

I understand that Nelson Vein & Surgical Services may use or disclose my protected health information for treatment, payment or health 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.

Nelson Vein & Surgical Services had detailed documentation called the 'Notice of Privacy Practices'. It contains a more complete description of your rights 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 Nelson Vein & Surgical Services 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 below means I agree to allow Nelson Vein & Surgical Services 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 Nelson Vein & Surgical Services has taken action relying on this consent.

Signature of patient or legal representation

Date

Relationship to the patient (if signed by another party)

Date

You may obtain a copy of our Notice of Privacy Practices, including and revisions of our 'Notice' at any time by contacting Nelson Vein & Surgical Services by mail at 30915 Lorain Road North Olmsted, Ohio 44070 or simply calling us at (440) 617-6061.

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