Notice of Privacy Practices
Written Acknowledgement Form

Our Notice of Privacy Practices provides information about how we may use and disclose medical information about you. As provided in our notice, the terms of our notice may change in accordance with Federal regulations. A current copy may be obtained by requesting a copy or by viewing the notice displayed in our office.

You have the right to request that we restrict how Protected Health Information (PHI) about you is used or disclosed. We are not required to agree to this restriction, but if we do, we are bound by our agreement. A request to restrict our use of your information must be done in writing to our practice Administrator at 173 Wadsworth Drive, North Chesterfield, VA 23236.

Richmond Vascular Center intends to use and disclose the minimum necessary personal health information (PHI) about you for treatment, payment, or health care operations. Other uses and disclosures not described as permitted in our Notice of Privacy Practices will require a current signed and dated authorization from you or your legal appointed representative.

I, ____________________________ (Please print patient name) have been provided with a copy of the Notice of Privacy Practices for Richmond Vascular Center.

_________________________________ ________________
Patient Signature Date

If patient is a minor or is unable to sign:

_________________________________ ________________ ___________________
Authorized Representative Date Relationship to Patient