Vanishing Veins
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Lori L. Greenwald, MD, FACS
Medical Director

Protected Health Information and Notice of Privacy Practices

Vanishing Veins enforces strict compliance with regulations of the 1996 Health Insurance Portability and Accountability Act (HIPAA). In addition to our legal obligation to maintain and safeguard the privacy of your protected health information, we are required to provide you with a notice of our legal obligations and privacy practices, and to abide by the terms of that notice.

Your protected health information (PHI) is information about you, created or obtained by us, including personal identification information, information about your past, present or future physical or mental health or condition, as well as information regarding payment for the provision of your health care. Our Notice of Privacy Practices describes the use and disclosure of your PHI that we are legally authorized to make, and our legal obligations with respect to the use and disclosure of your PHI. It also describes your rights to access and control your PHI. If you would like a copy of our Notice of Privacy Practices, you may request it at any time. It is also available on our website, www.vanishingveins.net.

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Please sign below to acknowledge you have read the above statement regarding our Notice of Privacy Practices.

I have read the above statement and **would like to receive a copy** of your Notice of Privacy Practices

Patient's Signature: ________________________________ Date: ____________________

I have read the above statement and **do not wish to receive a copy** of your Notice of Privacy Practices.

Patient's Signature: ________________________________ Date: _____________________

Note: With the exception of legally authorized disclosures, we will not disclose your PHI to anyone, including your spouse, without your express authorization. To authorize us to disclose information about your healthcare to another individual(s), please provide their name(s) and their relationship to you in the space below.
I authorize Vanishing Veins to release my protected health information to:

Individual(s):	Relationship to Patient:
____	______________________________________
____	______________________________________

Patient's Signature: ____ Date: ______________________

(You may revoke the above authorization at any time by providing Vanishing Veins with written notice.)

Rev.9/24/09