ATLANTA VASCULAR SPECIALISTS • VEIN SPECIALISTS OF GEORGIA
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# RECEIPT OF OUR NOTICE OF PRIVACY PRACTICES

Our notice of Privacy Practices provides information about how we may use and disclose protected health information about you. As provided in our notice, the terms of our notice may change. If so, you may obtain a revised copy by contacting Carol Daigle, RN or Connie Dillard, Practice Administrator. By signing below, you acknowledge that you have received a copy of our Notice of Privacy Policies on the date indicated below.

Print Name of Patient:______________________________________ Patient DOB: _____/_____/______

# RELEASE OF INFORMATION

[] I authorize the release of information including diagnostic, records; examination rendered to me and claims information. This information may be released to:

[] Spouse________________________________________

[] Child__________________________________________

[] Child__________________________________________

[] Child__________________________________________

[] Caregiver/Friend_________________________________

The Release of Information will remain in effect until terminated by me in writing.

# MESSAGES

Please call: [] my home [] my work [] my cell

Number___________________ Number___________________ Number___________________

If unable to reach me: (Choose One)
[] you may leave a detailed message
[] please leave a message asking me to return your call
[]_____________________________________

The best time to reach me is (day)_______________________ between (time)________________

Signed:________________________________________________ Date:__________________________

Witness:________________________________________________ Date:__________________________