Fayetteville Vascular and Vein Center, P.A

Michael A. Leke
American Board of Surgery Certified
Vascular and Endovascular Surgery

Notice of Privacy Practices

Patients Acknowledgement

Patients Name: _____ Date of Birth: _____

- I have received this practice's notice of privacy practices written in plain language. The notice provides in details the used and disclosures of my health information that may be made by this practice, my individual rights and the practice's legal duties with respect of my protected health information. The notice includes:
- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the firms of notice currently in effect.
- Types of uses and disclosure that this practice is permitted to make for each of the following purposes, Treatment, Payment and Health care options.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health care information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of uses and disclosures that will be made only by my written authorization and I may revoke such authorization at any time.
- My individual right with respect to protected health information and a brief description and how I may exercise these right in relation to;
    - The right to complain to this practice and to the secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
    - The right to request restrictions on certain uses and disclosure of my protected health information and that this practice is not required to agree to a request restriction.
    - The right to receive confidential communications of protected health information.
    - The right to inspect and copy my protected health information.
    - The right to amend protected health information.
    - The right to receive an accounting of disclosure of protected health information.
    - The right to obtain a paper copy of the privacy practices from this practice upon request.

This practice reserves the right to change the term of its notices of privacy practices and to make new provisions of effective for all protected health information that it maintains. I understand that I can obtain this practice's current notice of privacy upon request

Signature: _____ Date: _____