Fayetteville Vascular and Vein Center, P.A

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

PATIENT CONSENT

Patient Name: _____DOB: _____

Social Security Number: _____

By signing this consent form you are giving the providers and office staff permission to use and disclose your health information. Your health information will be used and disclosed to provide your care and treatment, to bill and collect payment for the services provided, and to perform necessary routine operations.

You have been provided with a copy of our "Notice of Privacy Practices" that contains a complete description of the uses and disclosures covered under this consent. You have been given time to review the "Notice of Privacy Practices" and we have encouraged you to read it and ask any questions that you may have prior to signing this consent.

Our Office reserves the right to change the privacy practices as stated in the "Notice of Privacy Practices". You will be given a copy of the revised notice with you first office visit following any change. The most current notice is prominently posted in our waiting room and our examination rooms. You may request a copy at any time.

You have the right to request that we restrict how your health information is used or disclosed. We are not required to agree to your request restriction, but if we do agree to the restriction, we will honor the restriction.

You have the right to revoke this consent except to the extent that we have already taken action covered under the consent. If you choose to revoke this consent, you must do so in writing

CONTACT INFORMATION

May we leave a message? ☐Yes ☐No

With whom may we discuss your health information? ☐Spouse Other_____

This consent must be signed the patient and dated

_____ _____

Signature of Patient or Responsible Party Relationship if Not Patient

_____

Date