Buffalo Endovascular & Vascular Surgical Associates

NOTICE OF PRIVACY PATIENT ACKNOWLEDGMENT FORM (HIPPA)

OUR NOTICE OF PRIVACY PRACTICES HAS BEEN DEVELOPED IN ACCORDANCE WITH THE FEDERAL HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA). THESE NATIONAL STANDARDS WERE DEVELOPED TO FURTHER PROTECT THE PRIVACY, CONFIDENTIALITY AND INTEGRITY OF PATIENT HEALTH INFORMATION. OUR STAFF WILL ENSURE THAT ITS PRACTICES AND STANDARDS COMPLY WITH HIPAA AND OTHER APPLICABLE FEDERAL AND STATE LAWS.

THE NOTICE PROVIDES INFORMATION ABOUT HOW WE MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION THAT IS PART OF YOUR MEDICAL RECORD; WHAT YOUR RIGHTS ARE AS A PATIENT TO RESTRICT DISCLOSURE; WHAT YOUR RIGHTS ARE TO OBTAIN AN ACCOUNTING OF DISCLOSURES AND WHAT OUR OBLIGATIONS ARE TO RELEASE YOUR HEALTH INFORMATION TO OTHER HEALTH CARE PROVIDERS, INSURANCE COMPANIES, REGULATORY, LAW ENFORCEMENT AND PUBLIC HEALTH AGENCIES.

BY SIGNING THIS FORM, YOU ACKNOWLEDGE THAT YOU HAVE RECEIVED A COPY OF THE NOTICE OF PRIVACY PRACTICES, WHICH BECAME EFFECTIVE APRIL 14, 2003. YOU HAVE THE RIGHT TO REVIEW THE PRIVACY NOTICE BEFORE SIGNING THIS FORM.

_____	_____
SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE	PRINTED NAME OF PATIENT OR AUTHORIZED REPRESENTATIVE
_____	_____
RELATIONSHIP IF OTHER THAN THE PATIENT	DATE
_____	_____
SIGNATURE OF WITNESS	PRINT NAME
_____	_____
SIGNATURE OF INTERPRETER (IF REQUIRED)	PRINT NAME