

NYU VEIN CENTER

530 First Avenue, Suite 6D ♦ New York NY 10016

PATIENT CONSENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), that I have certain rights to privacy regarding my protected health information.

I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physicians certifications.

I have read the New York University School of Medicine *Notice of Privacy Practices* booklet containing a complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing the consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Print name: _____ Date: _____

Signature: _____

Guardian or family member we can release information to:

_____ Relationship to Patient: _____