

# **ACKNOWLEDGEMENT FORM**

## **Acknowledgement of Receipt of Privacy Notice**

I have been presented with a copy of Vein Centers for Excellence of Kansas City's **Notice of Privacy Policies**, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the content of the Notice, and I request the following restriction(s) concerning the use of my personal medical information:

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Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

**Signed:** \_\_\_\_\_ **Date:** \_\_\_\_\_

If not signed by patient, please indicate relationship to patient (e.g., spouse)

**Relationship:** \_\_\_\_\_ **Witnessed by:** \_\_\_\_\_

**If the patient refuses to sign, indicate your attempt to obtain a signature below.**

[ ] Patient refused to sign this Acknowledgement

Date: \_\_\_\_\_

Time: \_\_\_\_\_

Employee Name: \_\_\_\_\_