VEIN CENTER
OF NORTH TEXAS

Clint A. Hayes, M.D.
1701 Highway 75 North
Sherman, Texas 75090
(903) 893-0123

Acknowledgment of Review of Notice of Privacy Practices

Medical Record and Summary Plan Document (SPD) Release

I understand that as part of the provision of the healthcare services, Vein Center of North Texas / Clint A. Hayes, M.D., P.A. creates and maintains health records and other information describing among other things, my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment.

I have been provided with a Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their Notice of Practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes, I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations (quality assessment and improvement activities, underwriting, premium rating, conducting or arranging for medical review, legal services, and auditing functions, etc.) and that the organization is not required to agree to the restrictions requested.

By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment and health care operations. In addition, I consent to have my medical records and SPD released to Dr. Hayes. I have the right to revoke this consent, in writing, except where disclosures have already been made in reliance on my prior consent.

This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this consent is as valid as this original.
3. I may revoke this consent at any time, except where information has already been released. This consent is valid until revoked by me in writing.
4. I have the right to request that the use of my Protected Health Information which is used or disclosed for the purposes of treatment payment or health care operations be restricted. Clint A. Hayes, M.D., P.A. is not bound by the restriction unless it is in agreement with the restriction.

Sharing information with other physicians and your insurance provider(s): In order to improve your care, we usually share information with your primary, referring, and other specialist physicians and your insurance provider(s). This information might include: history and physical, labs, ultrasound, x-ray, operative reports, etc.

Please list any additional person(s) you will allow this office to disclose information to. Please indicate what type of information may be disclosed (ie: billing, test results, general health information):

NAME	INFORMATION PERMISSIBLE TO BE DISCLOSED
1)	
2)	
3)	

PLEASE SIGN AND RETURN FOR OFFICE RECORDS

PATIENTS NAME (PRINTED) _____ DATE _____

PATIENTS SIGNATURE (OR GUARDIAN, IF MINOR) _____ SOCIAL SECURITY NUMBER _____