LIVING WATER
VEIN INSTITUTE
& MEDICAL SPA

Acknowledgement of Notice of Privacy Practices

We may call the telephone number you have provided and leave a message on an answering machine or with family/friend regarding your appointment or procedures.

I have been given the opportunity to review the **Notice of Privacy Practices** and understand that the Notice describes how my protected medical information may be used and disclosed and how I may get access to this information. I have also been given the opportunity to have a copy of the Notice of Privacy Practices for further review.

If for some reason the facility needs to relay my protected health information, i.e. results or billing issues, you can either leave or discuss the information with the following individual(s):

Name	**Relationship**	**Contact Number**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

By signing below, I agree to the fore mentioned statements.

_____ _____ _____

Print Patient Name Cell Date of Birth

_____ _____

Signature Date

_____ _____

Practice Representative Signature Date