Acknowledgement of Receipt ofNotice of Privacy Practices

I have been made aware of **PODIATRY INSTITUTE OF THE SOUTH'S**"Notice of Privacy Practices" ("Notice") I received a copy of this document on today's date, and I have a right to request additional copies in the future. The Notice describes the type of uses and disclosures of my protected health information that might occur during my treatment, to facilitate the payment of my bills or in the performance of **PODIATRY INSTITUTE OF THE SOUTH'S** health care operations. The Notice also describes my rights and **PODIATRY INSTITUTE OF THE SOUTH'S** responsibilities with respect to my protected health information.

I understand that copies of the Notice are available in the registration areas of each facility and on **PODIATRY INSTITUTE OF THE SOUTH'S** system's website at http:// www.vascularandveininstitute.com/. I understand I may request a copy of the Notice. **PODIATRY INSTITUTE OF THE SOUTH** reserves the right to change the privacy practices that are described in the Notice at any time and will make a revised Notice available for review. I may obtain a revised Notice of Privacy Practices by requesting a copy or by accessing **PODIATRY INSTITUTE OF THE SOUTH'S** website listed above to view the most current version.

_____ _____

Signature of Patient or Authorized Representative Date

_____

Relationship to Patient (if not signed by the patient)

_____ _____

Witness Signature Date

A COPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL