Acknowledgement of Receipt of Notice of Privacy Practices

I have been made aware of VASCULAR AND VEIN 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 VASCULAR AND VEIN INSTITUTE OF THE SOUTH's healthcare operations. The Notice also describes my rights and VASCULAR AND VEIN 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 VASCULAR AND VEIN INSTITUTE OF THE SOUTH's system website at www.vascularandveininstitute.com. I understand that I may request a copy of the Notice at any time. VASCULAR AND VEIN INSTITUTE F 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 VASCULAR AND VEIN INSTITUTE OF THE SOUTH's website listed above.

_____ _____

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 VALID AS THE ORIGINAL****