

## SUMMARY OF HIPAA PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Wisconsin Vein Center & MediSpa may use and disclose protected health information about me to carry out treatment, payment and healthcare operations. Additionally, Wisconsin Vein Center & Medi Spa may use and disclose appointment reminders, treatment alternatives and health related benefits and services either by mail or phone. When appropriate, Wisconsin Vein Center & MediSpa may share health information with a person who is involved in my medical care or payment for my care. Under certain circumstances, Wisconsin Vein Center & MediSpa may use and disclose information for research. We will disclose health information when required to do so by international, federal, state or local law, or to avert a serious threat to health or safety. Other entities include but are not limited to: business associates, organ and tissue donation organizations, and the military and workers compensation.

I understand I have a right to inspect copy and amend records. I have a right to an accounting of disclosures as well as being able to request restrictions on disclosures and request confidential communication with the office.

I further attest that I am aware that this is a summary of Wisconsin Vein Center & MediSpa's Privacy Notice and that I have been given the opportunity to obtain and review the notice in its entirety.

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patients Name (Print)

\_\_\_\_\_  
Guardian's Name (Print)

I authorize the disclosure of all of my medical health information to the individual(s) listed below. The authorization will remain in effect until I revoke it in writing.

\_\_\_\_\_  
Name of authorized individual(s)

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date