



A center exclusively for the treatment of varicose and spider veins



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Medical Director

The Notice of Privacy Practices is meant to inform you of the uses and disclosure of protected health information that we may make. It also describes your rights to access and control your protected health information and certain obligations we have regarding the use and disclosure of your protected health information.

Your “**protected health information**” is information about you, created and received by us, including demographic information that may identify you and that relates to your past, present or future physical or mental health or condition, or payment for the provision of your health care.

We are required by law to maintain the privacy of your protected health information. We are also required by law to provide you with this notice of our legal duties and privacy practices with respect to your protected health information and to abide by the terms of the notice that is currently in effect. However, we may change our notice at any time. **If you would like a copy of our Notice of Privacy Practices, please ask at the time of your appointment.**

If you do not want a copy of our Notice of Privacy Practices please sign below.

Signature: _____ Date: _____
I do not want a copy of the Notice of Privacy Practices.

To ensure patient confidentiality, **if there is anyone you would like to give us permission to speak to other than yourself regarding your care and test results, please write their name(s) in the space provided below. Even if you are married, we can not release any information to your spouse unless authorized by you.**

Name: _____ Date: _____

Name: _____ Date: _____

Print Patient Name: _____

Signature: _____ **Date:** _____