YAKIMA VASCULAR ASSOCIATES

A Member of MEMORIAL'S Family of Services

Yakima Vascular Associates

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NOTICE OF PRIVACY PRACTICES – ACKNOWLEDGEMENT OF RECEIPT

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so, or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting our Privacy Officer.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

I, _____ (Patient's name printed)

Authorize Yakima Vascular Associates to release any medical and/or billing information to:

Individual	**Relationship**	**Date of Birth**

By my signature below, I acknowledge receipt of the Notice of Privacy Practices.

Patient or Legally Authorized Individual Signature Date Time

Printed Name of Patient Date of Birth

Printed Name if Signed on Behalf of the Patient Relationship
(parent, legal guardian, personal representative)

This authorization may be revoked in writing at any time. However, a revocation would not affect any actions already taken by Yakima Vascular Associates based upon this authorization.