ATLANTIC VEIN INSTITUTE

HIPPA Patient Consent for Use and Disclosure
of Protected Health Information

I hereby give my consent for Atlantic Vein Institute (AVI) to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). I have the right to review the Notice of Privacy Practices prior to signing this consent and acknowledge that I have been made aware of the privacy policy of AVI as it pertains to the privacy and confidentiality of my medical records.

AVI may need to contact me about items that assist the practice in carrying out TPO, such as appointment reminders, insurance matters and items pertaining to my clinical care. In these instances:

May we phone you and leave a voicemail if we are unable to reach you?	YES	NO
May we email and/or text you to confirm appointments?	YES	NO
May we discuss your condition with any member of your family?	YES	NO

If YES, please name the members allowed: _____

With this consent, AVI may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I hereby authorize payment directly to David J. Swierzewski, MD dba Atlantic Vein Institute for the benefits otherwise payable to me for these services but not to exceed the reasonable and customary charge for those services. I understand that my insurance carrier may pay less or none of the charges for the services I receive and that I am responsible for payment in full of all charges.

By signing this form, I am consenting to allow AVI to use and disclose my PHI to carry out TPO.

_____
Signature of Patient or Representative

_____ _____
Print Patient or Representative's Name Date