



INSERT PATIENT LABEL HERE

Patient Consent For Use and Disclosure of Protected Health Information

Southern Vascular Associates LLC

With my consent, Southern Vascular Associates LLC may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations. Please refer to Southern Vascular Associates LLC Notice of Privacy Practices for a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent. Southern Vascular Associates LLC reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Southern Vascular Associates LLC Privacy Officer at 5000 Ambassador Caffery Pkwy Bldg 1 Ste 100, Lafayette, LA 70508.

With my consent, Southern Vascular Associates LLC may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out care, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Southern Vascular Associates LLC may mail to my home or other designated location any items that assist in carrying our care, such as appointment reminder cards and patient statements as long as they are marked personal and confidential.

However, the practice is not required to agree to meet requested restrictions, if it does, it is bound by this agreement.

By signing this form, I am consenting to Southern Vascular Associates LLC use and disclosure of my PHI to carry out care.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Southern Vascular Associates LLC may decline to provide treatment to me.

Signature of Patient/Legal Guardian

Date

Patient's Name Printed