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NOTICE OF PRIVACY PRACTICES

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information.
I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you agree, than you are bound to abide by such restrictions.

Signature ____ Date ___________________________

____ ___________________________

Person Authorized to Consent for Patient Relationship to Patient

PREVIOUS FILM ACKNOWLEDGEMENT

To ensure that we provide our patients with the best care and most accurate results,
we ask that you initial below as appropriate:

_____ Vena/RCW staff did inform me that I need to provide the technologists with any previous films/studies done on the body part(s) that is/are being scanned today. I have or will provide Vena with these images within the next 24 hours. I agree to pick up these films within the next 21 days. If I fail to pick these up, they will be destroyed.

--OR –

______These films should be returned to____

(Physician, Clinic or Hospital Name)

_____ I hereby state there have been no previous studies performed on the body part(s) being scanned today.

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: _________ Initials: ______ Reason:____