Valley Vein and Vascular Surgeons
Sammy Zakhary, MD, PC
Dana Garner, NP

Patient Name: _____ DOB: _____

Consent to Share Your Information

Communicating with you is a necessary part of our continued care of your medical health. We may need to communicate with you for various reasons including but not limited to lab results, appointment reminders, billing questions, etc. How may we contact you?

□ **It is ok to leave messages at this number - Cell Phone ( ) _____**

□ **It is ok to leave messages at this number - Home Phone ( ) _____**

□ **Please check this box if you <u>do not</u> want your medical information discussed or disclosed with any family members.**

Please list below the people we have your permission to release your health information to. For example, family members who may request information about your health:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

_____

Acknowledgement of Receipt of Notice of Privacy Practices

By signing below, I acknowledge that I have received a copy of Sammy A. Zakhary, MD, PC's "Notice of Privacy Practices". This Notice describes how Sammy A. Zakhary, MD, PC may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

Consent for Use or Disclosure of Information

I hereby permit Sammy A. Zakhary, MD, PC to use my health information, and/or to disclose my health information to any third party payor, or to any party involved in my healthcare. This may include records regarding drug, alcohol, or mental health treatment to the person listed above. I understand that there is a Notice of Privacy Practices posted in the practice reception area, available for me to read.

This consent shall be in force and effect as long as I am a patient at this practice. I understand that I have the right to revoke this consent, in writing, at any time by sending such written notification to my physician(s) at this practice. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I also understand that I have the right to:

- ✓ **Inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights).**
- ✓ **Refuse to sign this consent.**

Signature of Patient or Guardian: _____

Date Signed: _____