FOX VALLEY VEIN CENTERS
831 | E. Sandhurst Drive | Sandwich, Illinois | 60548
815.786.3222
James Hawkins, D.O. Brett Cassidy, M.D.

ACKNOWLEDGEMENT OF RECEIPT

Authorization for Disclosure/Notice of Privacy Practices

Patient Name: ____

The above named patient acknowledges receipt of Fox Valley Vein Centers, P.C. Notice of Privacy Practices provides detailed information about how the practice may use and disclose a patientís confidential information.

The above named patient understands that the practice reserves the right to change the privacy practices that are described in the Notice. The patient also understands that a copy of any Revised Notice will be provided or made available to the patient.

Signature: ____ **Date:** ________________

Relationship to patient: ____

NOTIFICATION OF TEST RESULTS

Please fill out this form which will detail how you would like our practice to disclose your personal information. It is the policy of our office to make available to you laboratory results, ultrasound and X-ray reports ordered by Aishling Obstetrics & Gynecology, S.C by phone or mail. If you have not heard from us in 14 days from the date of your test, please call our office.

Please check all acceptable options of notification of NORMAL test results:

_______ Patient
_______ Other:________________________________ Relationship: ________________________________
_______ I would prefer to call you to obtain results.
_______ You may leave message on my answering machine or voice mail at the following # _______________

Authorization to discuss personal health information:

In addition to myself, I authorize the staff at Fox Valley Vein Centers, P.C. to discuss my personal health information, including *abnormal* test results with:

Name: ____ Relationship: _______________________

Home: _________________________ Work: _______________ Cell: ______________________

Authorization to dispense medication(s):

I authorize ________________________________ relationship: ____________________ to pick up my medication(s) or any correspondence from the office of Fox Valley Vein Centers, P.C.

*****Person authorized to pick up medication(s) must present a photo ID*****

Authorization to discuss billing information:

I authorize ________________________________ relationship: ____________________ to discuss any billing information with the staff from my physician office or delegate from the billing service.

Please notify us of *ANY CHANGES* in the above.