1301 4th Ave NW suite #302
Issaquah, WA 98027

1900 116th Ave NE Suite 201
Bellevue, WA 98004

VEIN , VASCULAR & AESTHETIC ASSOCIATES

I hereby acknowledge that I have received a copy of the VIVAA PLLC's Notice of Privacy Practices

Patient Name (Please print): _____
I give my permission to release medical information, like appointments, treatment and/or care information to the following individuals below (family or friends, no doctors):

Name: _____ Phone # _____Relationship: _____

Name: _____ Phone # _____Relationship: _____

Signature: _____ Date: _____

If signed by a personal representative of the patient, please complete the following:

Personal Representative's Name: _____

Relationship to Patient: ☐ Parent
☐ Legal Guardian
☐ Holder of a Medical Power of Attorney

Witness Signature: _____ **Date:** _____

For Office Use Only

DOCUMENTATION OF ATTEMPT TO OBTAIN WRITTEN ACKNOWLEDGMENT OF THE DELIVERY OF THE NOTICE OF PRIVACY PRACTICES

I delivered VIVAA Notice of Privacy Practices to this patient or his/her personal representative but was unable to obtain an acknowledgement of the receipt of Notice of Privacy Practices because:

☐ Patient was unable to sign due to _____
☐ Patient refused to sign
☐ Notice of Privacy Practices acknowledgement was mailed to patient
☐ Other: _____

Employee Name: _____

Employee Signature: _____ Date: _____