DELAWARE VALLEY VEINS/ASSOCIATED VEIN SOLUTIONS

JOHN J. FLANAGAN, JR., M.D.

NOTICE OF PRIVACY PRACTICE

Receipt and Acknowledgement of Notice

Patient Name: ____

Date of Birth: ____

SSN: ____

I hereby acknowledge that I have received or have been given an opportunity to read a copy of Delaware Valley Veins/Associated Vein Solutions' Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact the Privacy Office of the practice at 610-933-2444.

____ ____________

Signature of Patient **Date**

____ ____________

Signature of Parent, Guardian or Personal Representative **Date**

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***If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power or attorney, healthcare surrogate, etc.)**

☐ **Patient Refuses to Acknowledge Receipt:**

____ ____________

Signature of Staff Member **Date**