

# Vivacity Clinic of Las Vegas

## PROTECTED HEALTH INFORMATION FORM

This form is for use and disclosure of Protected Health Information (PHI). The signed form will allow the practice to carry out treatment, payment, and healthcare operations.

**By signing this consent, I acknowledge and agree to the following:**

1. The privacy Notice includes a complete description of uses and/or Disclosures of my protected health information (PHI) necessary for the practice to provide the treatment for me, and also necessary for the practice to obtain payment for that treatment and to carry out the healthcare operations. The practice explained to me that the privacy notice would be available to me at my request. The practice has further explained my right to obtain a copy of the privacy notice prior to signing this consent, and encouraged me to read in accordance to applicable law.
2. The practice reserves the right to change its privacy practices that are described in its privacy noticed in accordance with applicable law.
3. The Practice's "Notice of Privacy Practices" is provided in the wall in waiting area. I may also request a copy of this once at a time.
4. This Notice of Privacy practices also describes my rights and the duties of this office with respect to my protected health information.
5. Please be advice that others may over hear conversation in our facility. A private room will be provided to discuss any personal conditions, treatment options or concerns you may have.

I \_\_\_\_\_, have read and understand the forgoing notice, and all my questions have been answered to my full satisfaction in a way that I can understand.

Patient's Signature: \_\_\_\_\_ Signed Date: \_\_\_\_\_