Annual Consent / Authorizations

UNIVERSITY VASCULAR

Patient Name: _____ DOB: _____

Consent for Treatment:

- Permission is hereby given for any medical / surgical procedures, x-rays, drug or laboratory test, medication or exam as may be deemed necessary by the Physician, Physician Assistant, or Nurse Practitioner.
- I understand I have the right to see a Physician if I choose, and have the right to see a Physician prior to any prescription drug or device order being carried out by an Advanced Practitioner.
- In the case of an emancipated minor, the consent below is being given on his or her behalf.

Consent to release Medical Information to a Spouse, Family Member or Significant Other:

Tell us with whom we may discuss your protected health information:
(Name and relation - example: Jane Doe, Wife)

1) _____ 2) _____ 3) _____

- I*f you do not authorize information to be release to anyone, please check this statement.*
  - ❑ **I do not authorize any information to be released to anyone other than myself.**

I hereby authorize messages to be left on a voice mail system or answering machine. Please indicate the number(s) University Vascular staff can utilize to leave a message for you:

1) _____ 2) _____ 3) _____

Financial Responsibility:

I understand it is the responsibility of each patient to arrange for payment for the medical services received in this office. I hereby authorize any insurance benefits to be paid directly to University Vascular and recognize my responsibility to pay for all non-covered services. I also authorize the release of any information necessary to process an insurance claim. Charges for all minors are the responsibly of the parent, guardian, or individual presenting the child for treatment.

I hereby authorize University Vascular or any of its affiliates, agents, contractors or business associates, to contact me by any telephone numbers, email addresses or other contact points provided by me or on my behalf. I understand I may be contacted by means of any automatic dialing system, pre-recorded forms of voice/messaging systems, electronic mail, text messages, telephone, or by cell phone for reasons related to the services, I received at University Vascular or payment of services received including but not limited to, debt collection purposes.

Acknowledgment of Receipt of Nondiscriminatory Act Notice:

☐ By initialing, I acknowledge that I received a copy of the Nondiscriminatory Act Notice.

Acknowledgment of Privacy Rights:

By signing below, I acknowledge that I am aware of University Vascular's Notice of Privacy Practices and Individual Rights. We may use or share your medical information with personnel involved in your care at University Vascular. We may also disclose your medical information to people outside the System, such as Health Information Exchanges. University Vascular's Notice of Privacy Practices contains more information about the policies and practices protecting the patient;s privacy.

I acknowledge that I have read the above, am giving my consent to the above, and am acknowledging I have been informed of my rights to privacy and have been given a copy of University Vascular's Policies and Notifications.

Signature :_____ **Date:** _____

Print Name: _____ **Email address:** _____