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**PATIENT ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES**

I hereby acknowledge that I have been presented with Valley Endovascular Associates' Notice of Privacy Practices.

Signature of Patient or Personal Representative

Date

Name of Patient or Personal Representative

Description of Personal Representative's Authority Authorization

I _____ request a copy of the Notice of Privacy Practices:
(Patient or Personal Representative's Name)
YES _____ NO _____

For Office Use:

If patient/representative required copy of Notice, date copy was provided: _____

If no acknowledgement could be obtained, state the reason why and the efforts taken to try to obtain the acknowledgement:

Employee Signature

Date

Employee Name