THE CENTER FOR SPINE HEALTH

Division of Radiology Associates of Northern Kentucky

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In order to comply with specific rules regarding **HIPAA** (Health Insurance Portability & Accountability Act of 1996), we ask that our patients complete this privacy and security of health information document.

Patient Name: _____ DOB: _____

It is our policy of Vascular & Interventional Associates (VIA) not to release confidential and/or unauthorized information by home telephone, answering machine, work telephone, voice mail, or cell phone. Information will not be left with an unauthorized person who may answer the phone without written authorization by the patient.

I authorize Vascular & Interventional Associates (VIA) and staff to leave information pertaining to my care by the following methods and will assume responsibility of notifying Vascular & Interventional Associates whenever this information changes.

I authorize Vascular & Interventional Associates (VIA) to leave messages regarding Medical information and insurance/billing information by the following methods**:**

☐ **Home answering machine** ☐ **Work voice mail**
☐ **Cell phone number** _____ ☐ **Other** _____

I hereby authorize Vascular & Interventional Associates to release information to the following individuals:

List Individuals: 1._____ **2.**_____

Patient Signature_____ Date: _____

PATIENT'S ACKNOWLEDGMENT

I acknowledge that I was offered the Notice of Privacy Practices for Vascular & Interventional Associates (VIA).

Patient Signature_____ Date: _____

In case you do not agree to sign this form, our office must indicate why you declined to do so.

Reason for patient's refusal: _____

Office Witness Signature: _____