Vein Center For Women P.C.
(DBA: Absolute Vein Care)
Girija S. Surya, M.D. (Board Certified in Cardiovascular and Thoracic Surgery)

Acknowledgement of Health Insurance Portability and Accountability Act (HIPAA) Privacy Notice *and* Designation Disclosure

I have received a copy of the Notice of HIPAA Privacy for the Physicians Practice.

Patient Name: _____ Date of Birth: __ __ / __ __ / __ __ __ __
(Please PRINT) (mm dd yyyy)

X _____ __ __ / __ __ / __ __ __ __
Signature Date (mm dd yyyy)

Use and disclosure of your medical information:

- We may disclose your Protected Health Information (PHI) for treatment to doctors, nurses, technicians, and medical providers to assist in treating the patient
- We may disclose your PHI for payment purposes
- We may also disclose PHI information to a Federal, State, or City Agency when requested and for any other purposes stated on the notice of Privacy Practices

Telephone, Written and Fax Communication

Home Phone # ( ) __ __ __ - __ __ __ __

- ❑ Ok to leave message with detailed information.
- ❑ Leave message with call back number only.

Cell Phone # ( ) __ __ __ - __ __ __ __

- ❑ Ok to leave message with detailed information.
- ❑ Leave message with call back number only.

Work Phone # ( ) __ __ __ - __ __ __ __

- ❑ Ok to leave message with detailed information.
- ❑ Leave message with call back number only.

Emergency Contact # ( ) __ __ __ - __ __ __ __

- ❑ Ok to leave message with detailed information.
- ❑ Leave message with call back number only.

Written Communication*:

- ❑ Ok to mail to my home address.
- ❑ Ok to mail to my work/office address.

Fax # ( ) __ __ __ - __ __ __ __

- ❑ Ok to fax with detailed information.

E-Mail: _____

- ❑ Ok to E-Mail with detailed information

*** If there is a payment due to the practice or if there is a balance, the account statements *will be mailed* to the Home address.**

I designate the following persons listed below as persons involved with my healthcare. I understand that I am not required to list anyone. I also understand that I may change this information anytime in writing.

Print Name:	Print Name:
Print Name:	Print Name:

X _____ __ __ / __ __ / __ __ __ __
Signature Date (mm dd yyyy)

670 North Beers St.
"Colonial Commons"
Bldg. 2, Ste. 4
Holmdel, NJ – 07733 - 1527

646 Rte. 18
"Plaza Hill"
Bldg. A Ste. 103
East Brunswick, NJ - 08816 - 3722

Ph: (732) 254-0500 **E-Mail: Contact@VeinCenterForWomen.com** **Fax: (732) 254-1558**
WWW.VeinCenterForWomen.com