ViaScan of Las Colinas

Acknowledgement of Receipt of Notice Privacy Practices

I have been provided with a Notice of Privacy Practices that provides me a more complete description of the uses and disclosures of certain health information. I understand ViaScan of Las Colinas reserves the right to change their Notice of Privacy practices and prior to implementation will provide an updated copy in the office which I may request in person at my appointment, by phone, or by email.

_____ _____/_____/_____

Patient's Printed Name **Date of Birth**

_____ _____

Legal Representative Printed Name **Relationship**

_____ _____/_____/_____

Patient/Legal Representative Signature **Date of Scan**

_____ _____/_____/_____

Witness Signature **Date**

The following names are the people that I would like to be involved in or have access to my protected health information on a routine basis. I give permission for ViaScan of Las Colinas to share my protected health information with:

_____ _____

Name **Relationship**

_____ _____

Name **Relationship**

_____ _____

Name **Relationship**