

Acknowledgement of Receiving

Mid Michigan Vascular Surgical, P.C.

Privacy Policy

Please check if we may leave phone messages on patients:

_____ Home Phone

_____ Cell Phone

_____ Other

Please check what information is allowed to be left on your messages:

_____ Appointment reminders or changes

_____ Testing information

_____ Schedule date of your procedure

We may discuss your medical information with the following personal contacts:

Name _____

Phone Number _____

Name _____

Phone Number _____

Name _____

Phone Number _____

By signing this document, I acknowledge this practice has a Privacy Policy

Patient or Legal Guardian Signature

Date of Birth

Date

Staff use only:

Witness Signature

Date

Documentation of failure to obtain sign Acknowledgement: Date _____

Presented this Acknowledgement of Receipt of Practice Privacy policy to _____ (patient) refused to provide a signature when requested

Witness Signature

Date