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Acknowledgement of Receipt of Privacy Practices

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

- I would like to receive a copy of any amended notice of privacy practices by email at: _____

Signature: _____ Date: _____

Print Name: _____ Date: _____

If not signed by patient, please indicate:

Relationship:

- Parent or Guardian if minor Patient
- Guardian or conservator of an incompetent patient
- Beneficiary or personal representative of deceased patient

Name of Patient: _____