

## **MY PERSONAL PHLEBOTOMIST MOBILE LAB LLC**

Mobile Specimen Collection Services

Marshall County, Tennessee

Phone: 615-631-8781

Email: darcy@mypersonalphlebotomist.com

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### **Notice of Privacy Practices**

**Effective Date: February 19, 2026**

My Personal Phlebotomist Mobile Lab LLC respects your privacy and is committed to protecting your protected health information (PHI).

We may use and disclose your health information for the following purposes:

#### **Treatment**

To provide specimen collection services and to send specimens to the laboratory designated by your ordering healthcare provider.

#### **Payment**

My Personal Phlebotomist Mobile Lab LLC operates as a self-pay mobile specimen collection service. Payment is due at the time of service and must be received prior to specimen collection unless prior arrangements have been made.

#### **Healthcare Operations**

For quality assurance, licensing, compliance, and general business management purposes.

We may also disclose your information as required by federal or state law.

We will not use or disclose your health information for purposes not described above without your written authorization.

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#### **Your Rights**

You have the right to:

- Request access to your health information
- Request corrections
- Request restrictions
- Receive confidential communications
- File a complaint without fear of retaliation

A complete copy of our full Notice of Privacy Practices is available upon request.

If you have questions about your privacy rights, please contact:

Darcy Del Rivero

Privacy Officer

Phone: 615-631-8781

Email: darcy@mypersonalphlebotomist.com

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### **Acknowledgment of Receipt**

I acknowledge that I have received or have been offered a copy of the Notice of Privacy Practices for My Personal Phlebotomist Mobile Lab LLC.

Patient Name (Printed): \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

If signed by personal representative:

Representative Name (Printed): \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Signature of Representative: \_\_\_\_\_

Date: \_\_\_\_\_

**For Office Use Only** (if patient refuses to sign):

Patient refused to sign acknowledgment

Staff Signature: \_\_\_\_\_

Date: \_\_\_\_\_