Foothill ARCADIA CALIFORNIA
VASCULAR CENTER

900 S First Ave, Ste E, Arcadia, Ca 91006
Phone: 626.585.9300 Fax: 626.585.9301

Patient Rights and Responsibilities

• You have the right to respectful care given by personnel which reflects consideration of your personal value of belief systems and which optimizes your comfort and dignity.

• You have the right to know what facility policies, rules, and regulations apply to your conduct as a patient.

• You have the right to expect emergency procedures to be implemented without unnecessary delay.

• You have the right to good quality care and high professional standards that are continually maintained and reviewed.

• You have the right to expect good management techniques to be implemented within this health care facility considering effective use of your time and to avoid your personal discomfort.

• You have the right to have a family member or representative of your choice and your physician notified promptly of your admission to the facility.

• You have the right to medical and nursing services without discrimination based upon race, color, religion, gender, sexual preference, handicap, national origin, or source of payment.

• You have the right to appropriate assessment and management of pain.

• You have the right, in collaboration with your physician, to make decisions involving your health care. This right applies to the family and/or guardian.

• While this healthcare facility recognizes your right to participate in your care and treatment to the fullest extent possible, there are circumstances under which you may be unable to do so. In these situations (e.g., if you have adjudicated incompetent in accordance with law, are found by your physician to be medically incapable of understanding the proposed treatment or procedure, are unable to communicate your wishes regarding treatment) your rights are to be exercised, to the extent permitted by law, by your designated representative or other legally designated person.

• You have the right to make decisions regarding the withholding of resuscitative services or the forgoing of or the withdrawal of life-sustaining treatment within the limits of the law and the policies of this institution.

• You have the right, upon request, to be given the name of your attending physician, the names of all other physicians or practitioners directly participating in your care, and the names and professional status of other health care personnel, including medical students, residents or other trainees, having direct contact with you.

• You have the right to every consideration of privacy concerning your medical care program. Case discussion, consultation, examination, and treatment are considered confidential and should be conducted discreetly, giving reasonable visual and auditory privacy when possible. This includes the right, if requested, to have someone present while physical examinations, treatments, or procedures are being performed, as long as they do not interfere with diagnostic procedures or treatments.

• You have the right to receive care in a safe setting, and be free from all forms of abuse and harassment.

• You have the right to have all information, including records pertaining to your medical care, treated as confidential, except as otherwise provided by law or third-party contractual agreements.

• You have the right to be free from restraint and seclusion not medically necessary or used as a means of coercion, discipline, convenience, or retaliation by staff.

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• You have the right to have your medical record read only by individuals directly involved in your care, by individuals monitoring the quality of your care, or by individuals authorized by law or regulation. You or your designated/legal representative, upon request, will have access to all information contained in your medical records, unless access is specifically restricted by the attending physician for medical reasons.

• You have the right to be communicated with in a manner that is clear, concise and understandable. If you do not speak English, you will have access, where possible, to an interpreter.

• You have the right to full information in layman's terms, concerning diagnosis, treatment, and prognosis, including information about alternative treatments and possible complications. When it is not medically advisable that such information be given to you, the information shall be given on your behalf to your designated/legal representative.

• Except for emergencies, the physician must obtain the necessary informed consent prior to the start of any procedure or treatment, or both.

• You have the right to expect protective services along with respect for your personal property.

• You have the right to change providers if other qualified providers are available.

• You have the right to not be involved in any experimental research, donor program, or educational activities unless you have, or your designated/legal representative has, given informed consent prior to the actual participation in such a program. You, or your designated/legal representative may, at any time, refuse to continue in any such program to which informed consent has previously been given.

• You have the right to accept medical care or to refuse any drugs, treatment, or procedure offered by the institution, to the extent permitted by law, and a physician shall inform you of the medical consequences of such refusal.

• You have the right to participate in the consideration of ethical issues surrounding your care, within the framework established by this organization to consider such issues.

• You have the right to formulate an "advance directive", or to appoint a surrogate to appoint health care decisions on your behalf. These decisions will be honored by this facility and its healthcare professionals, within the limits of the law and this organization's mission, values, and philosophy. You are responsible for providing a copy of your "advance directive" to the facility or caregiver.

• You are not required to have or complete an "advance directive" in order to receive care and treatment in this facility.

• You have the right to assistance in obtaining consultation with another physician at your request and expense.

• When this facility cannot meet the request or need for care because of a conflict with our mission or philosophy, or incapacity to meet your needs or request, you may be transferred to another facility when medically permissible. Such a transfer should be made only after you or your designated/legal representative have received complete information and explanation concerning the need for, and alternatives to, such a transfer. The transfer must be acceptable to the other institution.

• You have the right to examine and receive a detailed explanation of your bill.

• You have the right to full information and counselling on the availability of known financial resources for your healthcare.

• You have the right to expect that the facility will provide a mechanism whereby you are informed upon discharge of continuing healthcare requirements following discharge and the means for meeting them.

• You cannot be denied the right of access to an individual or agency that is authorized to act on your behalf to assert or protect the rights set out in this section.

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• Information regarding your rights as a patient should be provided to you at least one day prior to your procedure, unless the procedure is an emergency, scheduled within one day of the procedure time.

• You have the right, without recrimination, to voice complaints or express a grievance regarding your care and to have those complaints reviewed, and, when possible, resolved.

MEDICARE PATIENTS' RIGHTS:

• As a Medicare beneficiary, you have certain guaranteed rights. These rights protect you when you get health care; they assure you access to needed healthcare services; and they protect you against unethical practices. You have these Medicare rights whether you are in the Original Medicare Plan or another Medicare health plan. Your Rights include:

o The right to protection from discrimination in marketing and enrollment practices.

o The right to information about what is covered and how much you have to pay.

o The right to information about all treatment options available to you.

o The right to appeal decisions to deny or limit payment for medical care.

o The right to know how your Medicare health plan pays its doctors.

o The right to choose a women's health specialist.

o The right, if you have a complex or serious medical condition, to receive a treatment plan that includes direct access to a specialist.

o The right to receive emergency care.

PATIENT RESPONSIBILITIES:

• Provide accurate and complete information in matters concerning your health

• Make known if you do not understand instructions you are given.

• Assure that your financial obligation is fulfilled properly.

• To behave respectfully towards all healthcare professionals and staff as well as patients and visitors.

• Accept the consequences of not following medical advice.

• To follow the agreed upon treatment plan.

• For assuring there is a responsible adult available for transportation home and to remain with you as indicated by your physician or discharge instructions.

Patient Signature:_____ Date:_____

Witness_____

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Consent to Resuscitative Measures

CONSENT FORM FOR RESUSCITATION MEASURES FROM THE ACCESS CENTER

THIS IS NOT A REVOCATION OF ADVANCE DIRECTIVES OR MEDICAL POWER OF ATTORNEY LETTERS

All patients have the right to participate in their own decisions regarding their health and to make decisions regarding serious matters or execute their Power of Attorney Letters that authorize others to make decisions based on the wishes that patients express, when dealing with patients who do not have the capacity to make decisions or do not have the ability to communicate their decisions. This Access Center respects and upholds those rights.

However, unlike an acute care hospital, this Access Center does not routinely perform high-risk procedures. Most procedures performed at these facilities are considered minimal risk. It is also clear that no surgery is risk-free. You will have the opportunity to discuss the risks of your procedure with your doctor, who will be able to answer your questions regarding the associated risk, when you are expected to recover, and the care you will need after your surgery.

Therefore, and based on our Patient Rights policy regarding Advance Directives, regardless of the content of any advance directive or the instructions of a Designated Health Care Officer or an Attorney, if an adverse event occurs during your treatment at this Access Center, we will need to initiate resuscitation or other measures to stabilize the patient, and transfer you to an Acute Care Hospital for further evaluation. In the acute care hospital, the use of further treatments or the removal of a treatment that has already begun will be ordered either according to your wishes, Advance Directives for Serious Decisions, or a Health Power of Attorney. By agreeing to this policy by signing, you do not immediately revoke or render invalid any Health Care Instructions or Health Power Orders.

If you do not agree to this policy, we will be happy to assist you in scheduling the procedure for another date or provide you with a list of clinics for your consideration that may agree to perform the procedure without suspending your Advance Directive.

Please check the appropriate box by answering the following questions. Have you executed Advance Health Directives, a Will, a Power of Attorney that authorizes someone to make Health Care decisions on your behalf?

___ Yes, I have an Advance Directive, a Will, or a Health Power of Attorney.
___ No, I do not have an Advance Directive, a Will, or a Health Power of Attorney.
___ I would like more information regarding Advance Directives.

By signing this document, I acknowledge that I have read and understand its contents, and I agree to the policy as described. If I have indicated that I desire more information, I acknowledge by means of this document that I have already received that information.

Patient Signature:_____ Date:_____

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Patient Authorization and Financial Responsibility Form

PATIENT AUTHORIZATION AND FINANCIAL RESPONSIBILITY FORM

By signing this Patient Authorization and Financial Responsibility Form ("Form"), I request and consent to the provision of vascular access procedures and other services associated therewith by the Facility, Foothill Vascular Center. I further understand that I am personally responsible for payment for vascular access procedures and other services received at the above-mentioned outpatient facility ("Facility"), at the facility's usual and customary rates (available for my review upon request). My financial responsibility for my treatments will continue until my primary care physician and (if applicable) the Facility is reimbursed by the secondary insurers for such services, or the Facility releases me from that liability. In exchange for the center's treatment and services, I agree to the following:

1. **Authorization.** I authorize the Facility to obtain all health, insurance, and financial information from my physician, the hospital from which I was referred, or any other health care provider, as well as from my insurer, government program, and/or other third-party payer (including agents, administrators, or representatives), such as benefit and coverage information that is necessary for health treatment, payment and/or operational purposes. I also authorize the facility to provide protected health information to my insurer, government program, and/or other third-party payer (including copies of medical records) as necessary for health treatment, payment, and/or operational purposes.

2. **Insurance Payment.** I agree to assist the Center in any way possible in obtaining treatment authorization and payment for my treatment from my insurer, government program, and/or any other third-party provider. I agree to apply for benefits under any federal or state programs (including Medicare, Medicaid, state kidney funds, etc.) and secondary insurance plans, for which I may be eligible. I agree to provide all information, including medical records and/or personal financial data, that the Center may require for such programs from time to time.

3. **Medicare.** I certify that the information contained in my application for benefits under Title XVIII of the Social Security Act (the Medicare program) is true, correct, and complete in all respects. I authorize any possessor of medical or other information about me to provide to the Social Security Administration, or its intermediaries or insurers, any information necessary for any Medicare claim.

4. **Treatment Authorization.** I understand that if my insurer, government program, and/or any other third-party payer requires a treatment authorization prior to performing treatment and the facility is unable to obtain it in time for any reason, the facility may require me to (a) pay cash prior to receiving any of these treatments, or (b) transfer me to another facility (a list of facilities will be provided prior to transfer).

5. **Assignment of benefits; Lien.**

MEDICARE AND/OR MEDICAID: I hereby request that payment of Medicare/Medicaid benefits authorized to or on my behalf for services rendered at or by the Facility be made to the Facility, and I specifically assign such benefits to the Facility. I hereby certify that all information I have provided in connection with the application for benefits under Title XVIII of the Social Security Act is true, correct, and complete in all respects. **I understand that certain services may not be covered by the Medicare/Medicaid Program and that I may be responsible for the entire cost incurred for such services if there is other third-party coverage.** I also understand that all deductibles must be met within the timeframe specified by Medicare.

INSURANCE: I hereby assign to the Facility all rights, benefits, and interests under any insurance policy, health plan, workers' compensation, or other third-party payer responsible to me, in consideration for services rendered by the Facility. I hereby authorize payment directly to the Facility by any insurance policy, health plan, or third-party payer for treatment received at the Center. I hereby authorize payment directly to the Facility of Workers' Compensation coverage for medical expenses for treatment received at the Facility. I hereby authorize direct payment to the Facility of all third-party liability, third-party insurer, health, and individual liability insurance coverage for medical expenses incurred as a result of any accident, injury, or illness for which you have been treated at the Facility.

If I breach any of my obligations under this provision, I agree that the Facility will have an automatic lien on any payments I have received from any Policy. I further understand that the Facility may seek collections and all applicable legal rights and remedies against me. In this case, I will be responsible for any collection costs (including reasonable legal fees and costs) incurred by the Facility in connection with the pursuit of such collections.

PATIENT AUTHORIZATION AND FINANCIAL RESPONSIBILITY FORM

6. **Collection of Benefits/Legal Actions.** I agree to assist and cooperate fully with the Center in obtaining payment from any Plan for services, medications, or supplies provided to me (or my dependents) by the Center. This includes, without limitation, my participation as a plaintiff in any litigation, arbitration, appeal, or other action or demand in federal or state courts, at the Facility's expense, arising out of any dispute between the Facility and any of the Plans relating to any payment that the Facility alleges should be for services, drugs, or supplies provided by the Facility.

7. **Facility as an Authorized Representative.** I hereby authorize the Facility (including its attorneys and/or representatives) to act on my behalf and represent me, my dependents, and my estate, in the processing of a benefit claim or appeal of an adverse benefit resolution under any Plan. I hereby authorize the Facility and its attorneys to assert all available legal rights and remedies they deem appropriate to collect from the Plans such services, medications, or supplies. I hereby agree to follow any procedure established by any Plan to authorize the facility in this capacity.

8. **Patient deductible, coinsurance, and copayment.** For Medicare and certain other insurance companies where the Facility accepts the determination of the charge as payment in full, I am only responsible for my annual deductible, coinsurance, and copayments, if any. If I am a Medicare beneficiary, such financial responsibility may apply to clinical laboratory services performed by the facility.

9. **Cost Reduction and Cost Sharing (SOC).** I understand that if I participate in a state Medicaid program with a cost entry program, SOC, or other sharing program that requires me to share the cost of my health care, I agree to pay the initial weigh-in amount, SOC, or other cost-sharing designated by the state Medicaid provider at the time the services are rendered, or when the expense goes down, the SOC, or other shared amount is billed to me after the close of each month. I further understand and agree that if I am unable to pay any upfront expense, SOC, or other shared amount at the time the Facility provides the services to me, by signing below, I agree to pay such expense, SOC, or other co-sharing amount to the Facility as set forth in the Agreement.

10. **Changes to Information.** I agree to promptly notify the facility of any changes in my employment, insurance coverage, financial situation, or any other relevant personal information (e.g., address, last name, etc.), within two (2) business days of any change.

11. **Successors, Heirs, and Estate.** I desire that the obligations and representations contained herein be binding on my heirs, legal representatives, successors, and my estate. I agree not to assign my benefits under any Plan to any other person or company for services, medications, or supplies provided by the Facility.

This Form will remain in effect for as long as I receive treatment at the Facility and thereafter, until the Facility receives full payment for the services, medications, and supplies provided to me or my dependents by the Facility, or the Facility's claim for payment is settled or withdrawn. I understand that if I do not comply with the above terms and conditions, the facility may claim payment from me directly, as appropriate, and/or ask me to immediately transfer to another vascular access facility.

If any part of this form is held to be unenforceable, the remaining provisions will remain in full force and effect. I understand that I may retain an attorney at my own expense to represent me in connection with this Form.

The form has been explained to me in person in a language I understand, and all my questions have been answered to my satisfaction by the facility partner identified below.

I CERTIFY THAT I, THE UNDERSIGNED, BEING THE PATIENT OR ANOTHER PERSON LEGALLY AUTHORIZED TO ACT ON BEHALF OF THE PATIENT, HAVE READ PARAGRAPHS 1-11 OF THIS FORM, HAVE UNDERSTOOD THEIR CONTENTS, AND AGREE TO THEIR TERMS.

Patient Signature:_____ Date:_____

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This notice is effective February 16, 2026 and remains in effect until we replace it.

1. Our Pledge Regarding Medical Information

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

Our Legal Duty

Law requires us to:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices and your rights regarding your medical information.
3. Follow the terms of the current notice.

We have the right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of change to privacy practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

se and Disclosure of Your Medical Information

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us at the address provided at the end of this notice.

(*The rules described in this paragraph become effective February 16, 2026.*) If we receive substance use disorder treatment records created by a federally assisted program or health care provider under 42 CFR Part 2, we generally may only use or disclose those records in accordance with the written consent you provided to the program or provider. If, however, those records were disclosed to us with your written consent for treatment, payment and health care operations, we may further disclose the records for these purposes without obtaining an additional written consent.

FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

FOR PAYMENT: We may use and disclose your medical information for payment purposes. A bill may be sent to your or a third-party payer. The information on or accompanying the bill may include your medical information.

FOR HEALTH CARE OPERATIONS: We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs and getting the accreditation, certificates, licenses and credentials we need to serve you.

ADDITIONAL USES AND DISCLOSURES: In addition to using and disclosing your medical information for treatment, payment and health care operations, we may use and disclose medical information for the following purposes:

Facility Directory: Unless you notify us that you object, the following medical information about you will be placed in our facility directories: your name, your location in our facility, you condition described in general terms, your religious affiliation, if any. We may disclose this information to members of the clergy or, except for your religious affiliation, to others who contact us and ask for information about you by name.

Notification: We will use and disclose medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition or death. If you are present, we will get your permission if possible before we share, or give you the opportunities to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care.

Disaster Relief: We may share medical information with a public or private organization or person who can legally assist in disaster relief efforts.

Fundraising: We may provide medical information to one of our affiliated fundraising foundation to contact you for fundraising purposes. We will limit our use and sharing of information that describes you in general, not personal, terms and the dates of your health care. In any fundraising materials, we will provide you a description of how you may choose to not receive future fundraising communications.

Research in Limited Circumstances: We may use medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.

Funeral Director, Coroner, Medical Examiner: To help them carry out their duties, we may share the medical information of a person who has died with a coroner, medical examiner, funeral director or an organ procurement organization.

Specialized Government Functions: Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations and for government programs providing public benefits.

Court Orders and Judicial and Administrative Proceedings: We may disclose medical information in response to a court or administrative order, subpoena, discovery request or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

(*The rules described in this paragraph become effective February 16, 2026.*) If we receive substance use

disorder records created by a federally assisted program or health care provider under 42 CFR Part 2, we may not use or disclose those records, or testimony relaying the content of those records, in any civil, criminal, administrative, or legislative proceedings against you unless based on your specific written consent or a court order. We may only use or disclose records based on a court order after: (1) a notice and an opportunity to be heard is provided to you or the holder of the record, where required by 42 CFR Part 2; and (2) the court order is accompanied by a subpoena or other similar legal requirement compelling the disclosure.

Public Health Activities: As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to track products or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk for contracting or spreading a disease or condition.

Victims of Abuse, Neglect or Domestic Violence: We may use and disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety or the health or safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

Workers Compensation: We may disclose health information when authorized or necessary to comply with laws relating to workers compensation or other similar programs.

Health Oversight Activities: We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative or criminal investigations or proceedings, inspections, licensure or disciplinary action or other authorized activities.

Law Enforcement: Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises and crimes in emergencies.

Appointment Reminders: We may use and disclose medical information for purposes of sending you appointment postcards or otherwise reminding you of your appointments.

Alternative and Additional Medical Services: We may use and disclose medical information to furnish you with information about health-related benefits and services that may be of interest to you and to describe or recommend treatment alternatives.

4. Your Individual Rights

You have a right to:

1. Look at or get copies of certain parts of your medical information. You may request that we provide copies in a format other than photocopies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may get the form to request access by using the contact information listed at the end of this notice. You may also request access by sending a letter to the contact person listed at the end of this notice. If you request copies, we will charge you $_0_ for each page and postage if you want the copies mailed to you. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

2. Receive a list of all times we or our business associates shared your medical information for purposes other than treatment, payment and health care operations and other specified exceptions.

3. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).

4. Request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate your medical information to you by different means or at different locations must be made in writing to the contact person listed at the end of this notice.
5. Request that we change certain parts of your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.

6. If you have received this notice electronically and wish to receive a paper copy, you have the right to obtain a paper copy by making a request in writing to the contact person listed at the end of this notice.

Questions and Complaints

If you have any questions about this notice or if you think that we have violated your privacy rights, please contact us. You may also submit a written complaint to the U.S. Department of Health and Human Services. You may contact us to submit a letter of complaint or submit requests involving any of your rights in Section 4 of this notice by writing to the following address:

_____

_____

_____

_____

The address to file your complaint with the U.S. Department of Health and Human Services is below. We will not retaliate in any way if you choose to file a complaint.

Centralized Case Management Operations
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F HHH Bldg.
Washington, D.C. 20201

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Patient's name:_____DOB: _____

Patient's signature:_____Date: _____

Authorization to Disclose Protected Health Information

I authorize Foothill Vascular Center to disclose the **Protected Health Information (PHI)** described below

_____
[Name of Person or Entity]

_____ (_____).
[Address of Person/Entity] *[Phone Number]*

1. This Authorization covers the following time periods:

   ☐ _____ to _____ ☐ All past, present and future periods:
   [Insert Dates]

   a. ☐ I authorize the disclosure of **all my PHI for the above time period** (which may include information about mental health care, communicable diseases, HIV or AIDS, and treatment of alcohol/drug abuse).

   OR

   b. ☐ I authorize the disclosure of **all my PHI for the above time period <u>except</u> as noted below:**

      ☐ Do <u>not</u> disclose mental health records

      ☐ Do <u>not</u> disclose communicable disease records (including HIV and AIDS)

      ☐ Do <u>not</u> disclose alcohol/drug abuse treatment records

      ☐ Do <u>not</u> disclose other records (identify):_____

2. The purpose of this authorization is: ☐ Continued Care ☐ Insurance/Disability ☐ Litigation

   ☐Personal Reasons ☐Other _____.

3. This Authorization shall be in force and effect until _____, at which time this Authorization expires.
   [*Date or Event*]

4. I understand that I have the right to revoke this Authorization at any time by submitting a written request to the Covered Entity, except to the extent that action has been taken in reliance on it.

5. I understand that my treatment will not be conditioned on whether I sign this Authorization.

6. I understand that information disclosed pursuant to this Authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

   ☐ Patient Declines at this time

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Print Name of Patient or Personal Representative Relationship to Patient