



Valley Institute of Prosthetics and Orthotics, Inc.

PATIENT NAME _____

**Acknowledgement of Receipt of
“Notice of Privacy Practices”**

You may access VIPO’s “Notice of Privacy Practices” on the web at:
<http://www.vipoinc.com/docs/Document.pdf>

By my signature on this form, I certify that I have received a Notice of Privacy Practices.

The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of Valley Institute of Prosthetics and Orthotics, Inc. health care operations.

The Notice of Privacy Practices also describes my rights and the duties of Valley Institute of Prosthetics and Orthotics, Inc. with respect to my protected health information. [The Notice of Privacy Practices is posted in the lobby of VIPO’s office at 1524 21st Street.]

Valley Institute of Prosthetics and Orthotics, Inc. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail, or by asking for one at the time of my next appointment.

PATIENT COMPLETE THIS SECTION:

IF PATIENT IS A MINOR OR INCAPACITATED ADULT,
PATIENT REPRESENTATIVE/GUARDIAN COMPLETE SECTION BELOW:

PATIENT NAME (Printed)

PATIENT’S REPRESENTATIVE (Name printed)

PATIENT SIGNATURE

PATIENT’S REPRESENTATIVE SIGNATURE

DATE

RELATIONSHIP TO PATIENT

DATE