VSS
VenaStixSTAT

HIPAA Notice of Privacy Practices & Patient Acknowledgment

VenaStixSTAT, LLC – Mobile Phlebotomy Services

Phone: 520-414-7678

Email: venastixstat@gmail.com

Website: www.VenaStixSTAT.com

NOTICE OF PRIVACY PRACTICES

This Notice describes how your protected health information (PHI) may be used and disclosed and how you can obtain access to this information. Please review it carefully. VenaStixSTAT is committed to protecting the privacy and confidentiality of your medical information in accordance with the Health Insurance Portability and Accountability Act (HIPAA).

How We May Use and Disclose Your Health Information

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

Treatment: To provide mobile phlebotomy services and communicate with your physician, healthcare provider, or laboratory.
Payment: To obtain payment for services provided when applicable.
Healthcare Operations: To improve the quality of our services, maintain records, and comply with legal and regulatory requirements.
As Required by Law: When federal, state, or local laws require disclosure.
Public Health Activities: As permitted by law.
Health Oversight Activities: For audits, inspections, investigations, or licensing.
To Prevent Serious Threats to Health or Safety, when permitted by law.

We will not use or disclose your health information for marketing purposes without your written authorization unless otherwise permitted by law.

Your Rights

You have the right to:

Request access to your medical records.
Request corrections to your health information.
Request restrictions on certain uses or disclosures.
Request confidential communications.
Receive a copy of this Notice.
File a complaint if you believe your privacy rights have been violated.

To exercise these rights, contact VenaStixSTAT using the information listed above.

PATIENT ACKNOWLEDGMENT OF RECEIPT

I acknowledge that I have received or been offered a copy of the VenaStixStat Notice of Privacy Practices.

Patient Name: _____

Patient Signature: _____

Date: _____

If signed by personal representative

Representative Name: _____

Relationship to Patient: _____

Representative Signature: _____

Date: _____

OFFICE USE ONLY

Date Notice Provided: _____

Staff Member: _____