

Horizon Vascular Specialists

1003-A West Seventh St Frederick, MD 21701	9715 Medical Center Dr Suite 105 Rockville, MD 20850	20410 Observation Dr Suite 100 Germantown, MD 20876	18111 Prince Philip Dr Suite 226 Olney, MD 20832
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PERSONAL REPRESENTATIVE, FAMILY OR OTHER ENTITIES AUTHORIZED ACCESS TO PROTECTED HEALTH INFORMATION TO BE USED AND/OR DISCLOSED

Name or specifically identify these persons and/or other entities you are authorizing to make use of and/or to disclose your protected health information regarding treatment, payment and other healthcare operations other than yourself.

Name of Authorized Person or Entity	Relationship	Phone #
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AUTHORIZATION FOR USE OF ANSWERING MACHINE AND/OR VOICEMAIL

Horizon Vascular Specialists physicians and staff routinely are unable to contact patients directly during normal business hours. On these occasions our offices leave messages on communication devices provided by our patients. Due to the federally mandated HIPAA Privacy Rule, we must obtain your authorization to continue this mode of communication. Protected Healthcare Information that we may possibly disclose on your home, work, or cell phone would include, but is not limited to: test/lab results, prescription/pharmacy information, appointment instructions for visits, ultrasound, procedures, and surgical scheduling information.

_____ (Initial) Yes, I agree to allow Horizon Vascular Specialists physicians and staff to leave messages that include Protected Healthcare Information on the following: (Please initial next to the applicable.)

_____ Home Number _____ Work Number _____ Cell Number

_____ (Initial) No, I do not agree to allow Horizon Vascular Specialists' physicians and staff to leave messages that include Protected Healthcare Information on my home, work, or cell phone.

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION TO BE USED AND/OR DISCLOSED FOR THE PURPOSE OF CONTINUITY OF CARE

_____ (Initial) Yes, I agree to allow Horizon Vascular Specialists physicians and staff to release Protected Healthcare Information to medical facilities including, but not limited to hospitals, physician offices, pharmaceutical/medical device companies, testing facilities, etc. for the purpose of continuity of care.

_____ (Initial) No, I do not agree to allow Horizon Vascular Specialists physicians and staff to release Protected Healthcare Information to medical facilities including, but not limited to hospitals, physician offices, pharmaceutical companies/medical device, testing facilities, etc. for the purpose of continuity of care.

Patient Signature

Date