

## NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment both directly and indirectly.
- Obtain payment from third-party payers (insurance companies).
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that Horizon Vascular Specialists and Doctors Vascular Laboratory have the right to change its Notice of Privacy Practices from time to time and that I may contact the office during normal business hours to request a copy of the of the current Notice of Privacy Practices. **Horizon Vascular Specialists specifically prohibits the audio or video recording of any treatment procedures.**

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand that you are not required to agree to my restrictions, but if you do agree then you are bound to abide by them.

We have chosen to participate in the Chesapeake Regional Information System for our Patients, Inc. (CRISP), a statewide health information exchange. As permitted by law, your health information will be shared with this exchange. This will provide faster access, better coordination of care, assist providers and public health officials in making more informed decisions. You may "opt-out" and disable all access to your health information available through CRISP by calling 1-877-952-7477 or completing and submitting an Opt-Out form to CRISP by mail, fax or through their website at [www.crisphealth.org](http://www.crisphealth.org).

Patient Name: \_\_\_\_\_

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

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

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### FOR OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of receipt of a copy of our Notice of Privacy Practices and was unable to do so as documented below:

Date:	Employee Initials:	Reason:
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**Horizon Vascular Specialists      Doctors Vascular Laboratory**  
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