

## HIPAA / PRIVACY NOTICE

As a patient of Vascular Associates of Connecticut, LLC., we want to provide you with the best possible care. We want you to feel free to make full disclosure of information to the physician so that effective treatment can be provided. As required by the privacy provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Vascular Associates of Connecticut, LLC., is providing you, the patient of the patient's legal representative, with a copy of our Privacy Notice. HIPAA regulations require us to provide this information to you and to obtain your signature of the signature of your legal representative as proof that you have received our Privacy Notice.

Our policy is to protect the confidentiality, integrity, and security of the protected health and personal information of our patients and to prevent unauthorized access to, or the use of such information. This policy applies to both current and former patients.

Protected Health Information (PHI) is individually identifiable health and personal information and includes any information obtained by Vascular Associates of Connecticut, LLC., in connection with providing health care treatment, obtaining payment and related healthcare operations. This relates to past, present for future information that Vascular Associates of Connecticut, LLC., receives from you as our patient.

We will use this information to provide caring and quality medical care for you. Examples of PHI include diagnosis treatment and communications, both oral and written and including answering machines, voice mail and e-mail, used for follow-up, appointment scheduling, reminders, and test results reporting. As part of our standard healthcare operations, we may share this information with a facility such as a hospital, laboratory, diagnostic service or healthcare provider to coordinate your treatment plain in the most efficient manner. For insurance carriers, your information will be used for claim submission and to obtain payment for services provided. We will exchange data with your insurance carrier for activities such as confirming your eligibility with the plan, benefit and coverage determinations, and pre-certification/authorization and utilization review.

Your information is maintained in our office in our practice management information system. We also maintain information about you in your medical chart. Vascular Associates of Connecticut, LLC., limits access to your PHI to those employee's and business associates who need to know this information and we restrict the types and amount of information provided to the which is "minimally necessary" in order to carry out their work. We do not disclose PHI to third parties for purposes other than treatment, payment or health care operations unless the following exception occur:

- We receive a signed authorization from you to release your individually identifiable information. Vascular Associates of Connecticut, LLC., will provide you with an Authorization from that will need to be signed by your, the patient, or in the case of a minor, his/her guardian. This authorization will be for a defined period of time and may be cancelled by you, the patient, or in the case of a minor, by his/her guardian at any time.
- Federal, state or other applicable law requires us to share PHI
- Workers' Compensation purposes

You have the right to request a review of your PHI, to amend your records, and request restrictions on how your PHI is used. You may request an accounting of how your PHI has been disclosed. Any request for amendments or restrictions to the use of your PHI must be in writing. You have a right to request a copy of your medical record. Vascular Associates of Connecticut, LLC., will make every effort to provide you with your record within a reasonable amount of time and subject to normal copying charges. If you have any questions, comments or complaints regarding the management of your PHI, please contact the office at 860.246.4000 and ask for the practice administrator.

I acknowledge that I have received the above Vascular Associates of Connecticut, LLC., Privacy Notice.

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

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

## CONSENT FOR TREATMENT AND RELEASE OF INFORMATION

I authorize Vascular Associates of Connecticut, LLC., use and disclosure of all individual personal, health, financial and demographic information (known as Protected Health Information or PHI) for the purpose of:

- Providing medical treatment
- Obtaining payment and reimbursement
- Obtaining authorizations from my insurance for tests/procedures (when applicable)
- Requesting healthcare service from other providers
- Cooperating with other providers in my medical treatment
- Fulfilling requests for information when specifically authorized by me
- In addition, doing all other things directly related to providing healthcare to me

The above purpose and all other uses are known collectively as Treatment, Payment and Other healthcare options (aka TPO)

I authorize any physician or healthcare facility to provide upon request any PHI to Vascular Associates of Connecticut, LLC., when needed for the of TPO.

I consent to Vascular Associates of Connecticut, LLC., discussing any or all of my medical care including my evaluation, treatment, diagnosis even if related to psychiatric or psychosocial impairments, substance abuse, acquired immunodeficiency virus, HIV-related opportunistic infections, or pregnancy with the following persons:

1. \_\_\_\_\_ Relationship: \_\_\_\_\_
2. \_\_\_\_\_ Relationship: \_\_\_\_\_
3. \_\_\_\_\_ Relationship: \_\_\_\_\_
4. \_\_\_\_\_ Relationship: \_\_\_\_\_
5. \_\_\_\_\_ Relationship: \_\_\_\_\_

I consent to Vascular Associates of Connecticut, LLC., leaving messages on my answering machine, voice mail or cell phone. I have been given the opportunity to review Vascular Associates of Connecticut, LLC., Privacy Notice.

I understand my rights to restrict the use and disclosure of PHI and to revoke this consent at any time in writing.

I understand that should I choose not to consent to the terms and conditions of Vascular Associates of Connecticut, LLC., Privacy Notice, the practice has the right to and will withhold treatment except where required by law.

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

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

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

The Health Insurance Portability and Accountability Act of 1996 prohibits the use and disclosure of protective health information for treatment, payment and other healthcare operations without consent and prohibits the use and disclosure of protective health information for non healthcare related activities without specific and explicit authorization.