

**VASCULAR SURGERY ASSOCIATES, P.A.  
AND  
VEIN INSTITUTE OF THE MIDWEST**

**HIPAA  
PRIVACY POLICY**

HIPAA is an acronym for the Health Insurance Portability & Accountability Act of 1996 (a federal law). Of significant concern to healthcare organizations is the Administrative Simplification section of the Act, which requires healthcare organizations to comply with specific rules regarding:

- Unique Identifiers for health plans, providers, individuals, employers
- Healthcare Transactions & Code Sets for transmitting data electronically
- Privacy Regulations over disclosure and use of health information
- Security Regulations over protections of electronic health information

All of these rules have been developed by the Department of Health & Human Services.

I AUTHORIZED VASCULAR SURGERY ASSOCIATES TO CONTACT ME BY THE FOLLOWING METHODS:

Home Telephone/Answering Machine \_\_\_\_\_  
Work Telephone \_\_\_\_\_  
Cell Telephone \_\_\_\_\_  
E-Mail \_\_\_\_\_  
Other: \_\_\_\_\_

It is the policy of Vascular Surgery Associates NOT to release confidential information regarding your medical care to any unauthorized person(s). Please designate below the individuals you would like to specify as "authorized".

IF YOU WOULD LIKE TO HAVE INFORMATION RELEASED TO SOMEONE OTHER THAN YOU, PLEASE COMPLETE THE FOLLOWING:

AUTHORIZED PERSON(S):

Spouse: \_\_\_\_\_

Parent(s): \_\_\_\_\_

Others:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

MY SIGNATURE SERVES AS ACKNOWLEDGEMENT OF THE PRIVACY POLICY AND A COPY OF SUCH POLICY HAS BEEN OFFERED AND/OR GIVEN TO ME. I ASSUME THE RESPONSIBILITY OF NOTIFYING VASCULAR SURGERY ASSOCIATES WHENEVER MY CONTACT AND/OR AUTHORIZATION INFORMATION CHANGES.

X \_\_\_\_\_  
Signature

\_\_\_\_\_  
Date