



NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

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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 directly or indirectly be involved in that treatment.

Obtain payment from third-party payers.

Conduct normal healthcare operations such as quality assessments, data analysis for anonymous use in scientific publications, and physician certifications.

In accordance with the final HIPAA omnibus rule, January 25, 2013, Champlain Ophthalmology will not disclose your personal health information for the purpose of marketing or fundraising and will never sell your information.

We will also provide you with an electronic version of your medical records if requested in writing.

The patient now has the right to restrict certain disclosures of Protected Health Information to a health plan where the individual pays out of pocket in full for the healthcare item or service.

Champlain Ophthalmology now offers "Shared Care" through our electronic medical records system MD IntelleSys. If you have another physician who uses the same electronic medical records we can share and receive your medical records. Please let the front office know you would like this.

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

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____