



Cardiovascular Associates
of the Delaware Valley

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Cardiovascular Associates of the Delaware Valley, P.A.

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ASSURANCE OF PRIVACY FOR OUR PATIENTS

To Our Valued Patient:

The misuse of Personal Health Information, (PHI), has been identified as a national problem causing patients inconvenience, aggravation and money. We want you to know that all of our employees, managers and doctors continually undergo training, so they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act, (HIPAA), with particular emphasis on the "Privacy Rule". We strive to achieve the very highest standards of ethics and integrity when performing services for our patients.

It is our policy to properly determine appropriate use of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We realize there is always room for improvement! It is our policy to listen to our patients and our employees. If you feel your privacy has been compromised in any way, please ask to speak with one of our office managers.

Please read the following "Notice of Privacy". After reading, sign and return this form to the receptionist. If you have any questions, please ask. Thank you.

NOTICE OF PRIVACY

The Dept. of Health and Human Services has established a "Privacy Rule" to help ensure that personal information, (PHI), is protected. The Privacy Rule is the standard for healthcare providers to follow when disclosing patient health information that is needed to carry out proper treatment, health care operations and billing.

As our patient we want you to know that we respect the privacy of your personal medical records, and we will do all we can to secure and protect that privacy. When it is appropriate and necessary, we provide the minimum amount of information to only those we feel are in need of your health care information.

We also want you to know that we support your full access to your personal medical record. If you want to request restrictions pertaining to other parties receiving your medical information, please provide our staff with that information and it will be documented in your chart. You will be asked to authorize release of PHI to any party not directly connected with your treatment, healthcare operations or billing.

If you have any questions, comments or objections to the privacy policies on this form, please ask to speak with one of our office managers. You have the right to review our entire privacy policy manual upon request. Please sign below to acknowledge that you have read this notice.

Patient Name, (PRINT) _____

Patient Signature _____ Date _____

If patient is a minor, signature of parent or guardian _____