

# Michael A. Vasquez, MD, FACS, RVT

Glenn Buczkowski, RPA-C

Esther Sprehe, ANP

*Vascular & General Surgery*

## 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:

1. Conduct, plan and direct my treatment and follow-up among the multiple Healthcare providers who may be involved in my treatment directly and indirectly.
2. Obtain payment from third-party-payers.
3. Conduct normal healthcare operations such as: quality assessments and physician certifications.

I have received, read, and understand the *Notice of Privacy Practices* in brief descriptions as above stated. I understand that Dr. Michael Vasquez has the right to change its *Notice of Privacy Practices* from time to time and that I may contact Nicole Grega at anytime to obtain a current copy of the *Notice of Privacy Practices*.

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 you are not required to agree to my requested restrictions but if you do agree then you are bound to abide by such restrictions.

1) May we leave a message on an answering machine regarding appointments or medical information? YES  NO

2) If you have an office voicemail, may we leave a message for you on it regarding appointments or medical information? YES  NO

3) May we leave a message with anyone else in your home regarding appointments or medical information? YES  NO

If other than someone in your home:

Person Name: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

Phone Number: \_\_\_\_\_

4) May we send you a notice in the mail regarding appointments or medical information? YES  NO

5) If you have a cell phone, may we leave a message on it regarding appointments or medical information? YES  NO

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

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Relationship to Patient: \_\_\_\_\_

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

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

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**OFFICE USE ONLY**

I attempted to obtain patient's signature in acknowledgement on this Notice of Privacy Practices, but was unable to do so as documented below

Date: \_\_\_\_\_ Initials: \_\_\_\_\_ Reason: \_\_\_\_\_