MIDDLETOWN VALLEY FAMILY MEDICINE

300 South Church Street
P.O. Box 20
Middletown, MD 21769
(301) 371-9000
(240) 566-7000 Fax

Acknowledgement of Notice of Privacy Practices

Patient Name: _____ Date of Birth: _____

Preferred Phone Number: _____

Communication Authorization

1. Provider may contact me at my home/work phone numbers, or my home address regarding my diagnosis, results, treatment and care, or payment. I may request any other means of communication (such as e-mail, cell phone, or mail to different address) or I may deny a particular means of communication in writing (below).

Yes, you may e-mail me at _____.
I understand e-mail is **NOT** considered a private/secure method of communication.

Yes, you may call my cell phone at _____. I understand cell phones are **NOT** considered a private/secure method of communication.

No, please ***do not*** contact me by the following means: _____

2. I authorize my provider to share medical/billing information about my care/account to the following:

Name(s)	Relationship(s)	Phone #(s)
_____	_____	_____
_____	_____	_____

Communication authorization shall be expired under any circumstances as listed below:

1. Upon written request for records release for reason of transfer of care.
2. Upon written request by patient or legally responsible person.
3. In the case of a minor having reached the age of majority.

CRISP Participation

We have chosen to participate in the Chesapeake Regional Information System for our Patients (CRISP), a regional health information exchange serving Maryland and D.C. As permitted by law, your health information will be shared with this exchange in order to provide faster access, better coordination of care and assist providers and public health officials in making more informed decisions. You may "opt-out" and disable access to your health information available through CRISP by calling 1-877-952-7477 or completing and submitting an Opt-Out form to CRISP by mail, fax, or through their website at www.crisphealth.org. Public health reporting and Controlled Dangerous Substances information, as part of the Maryland Prescription Drug Monitoring Program (PDMP), will still be available to providers.

Acknowledgement of Receipt of Privacy Notice:
I, patient (or representative for patient) of Middletown Valley Family Medicine, have been given a copy of the Privacy Policy. I understand my rights according to this policy and that HIPAA law grants authorization to use and disclose my medical records for treatment/care and payment operations.

_____ _____ _____
Patient or Legally Responsible Person's Signature Date Witness/Date

Office Use Only
Entered By: _____ Date: _____