NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully. You have the right to obtain a paper copy of this notice upon request.

Patient Health Information
Under federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment and related medical information. Your health information also includes payment, billing and insurance information.

How We Use Your Health Information
We use health information about your for treatment, to obtain payment, and for health care operations, including administrative purposes and evaluation of quality of care you receive. Under some circumstances, we may be required to use or disclose the information even without your permission.

Example of Treatment, Payment and Health Care Operations
Treatment: We will use and disclose your health information to provide you with medical treatment or services. We may disclose the information to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, and to family members who are helping with your care.
Payment: We may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payments from your health plan.
Health Care Operations: We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment, and to assess the care and outcomes of your case and others like it.

Special Uses
We may use your information to contact you with appointment reminders. We may do this by way of an answering machine or one who answers your telephone.

Other Uses and Disclosures
We may use and disclose identifiable health information about you for other reasons, even without your consent. Submit to certain requirements, we are permitted to give out health information without your permission for the following purposes:
Required by Law: We may be required to report gunshot wounds, suspected abuse or neglect, or similar injuries or events.
Research: We may also use or disclose information for approved medical research.
Health oversight: We may be required to disclose information to assist in investigations or audits, eligibility for government programs, and similar activities.
Judicial and Administrative proceedings:
We may disclose information in response to an appropriate subpoena or court order.
Law Enforcement Purposes: Subject to certain restrictions, we may disclose information required by law enforcement officials.
Deaths: We may report information regarding deaths to coroners, medical examiners, funeral directors and organ donation agencies.
Serious threat to health or safety: We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
Military and Government Functions: If you are a member of the armed forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes.
Workers Compensation: We may release information about you for workers compensation or similar programs providing benefits for work related injuries or illness.

In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign and authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

Individual Rights
You have the following rights with regard to your health information. Please contact the person listed on this form to obtain the appropriate form for exercising these rights.
Request Restrictions: You may request restrictions on certain uses and disclosures of your health information. We are not required to agree to such restrictions, but, if we do agree, we must abide by those restrictions.
Confidential Communications: You may ask us to communicate confidentially by, for example, sending notices to a special address or not using postcards or phone/voicemail to remind you of appointments/results.
Inspect and Obtain Copies: In most cases, you have the right to look at or get a copy of your health information. There may be a charge for the copies.
Amend Information: If you believe that information in your record is incorrect, or, if important information is missing, you have the right to request that we correct the existing information or add the missing information.
Accountings of Disclosure: You may request a list of institutes where we have disclosed health information about you for reasons other than treatment, payment, or health care operations.

Complaints
If you are concerned that we have violated your privacy rights, or, if you disagree with a decision we have made about your records, you may contact the person listed below. You also may send a written complaint to the Department of Health and Human Services. The person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.

Contact Person
If you have any questions, requests, or complaints, please contact:

Annapolis Internal Medicine, LLC
Attn: Claudia Cicchetti, Office Manager
116 Defense Highway, Suite 400
Annapolis, MD 21401-7050
(410) 897-9841 phone (410) 897-9852 fax

I, _____,
Patient Name (please print)

hereby acknowledge receipt of the Notice of Privacy Practice given to me.

_____
Signature

_____
Date

If not signed, reason why acknowledgement was not obtained with Staff Witness seeking acknowledgement with date.

_____
Reason signature not obtained

_____
Staff Signature

_____
Staff Name (Print) Date