

Anne Arundel Gastroenterology Associates, P.A.

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. This notice is federally mandated.

**If you have any questions about this Notice please contact:
our Privacy Officer who is**

**Gary M. Evans, Administrator
AAGA
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Annapolis, Maryland 21401**

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices by accessing our website **aagastro.com**, calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information Based Upon Your Written Consent

You will be asked by your physician to sign a consent form. Once you have consented to the use and disclosure of your protected health information for treatment, payment and health care operations by signing the consent form, your physician will use or disclose your protected health information as described in this Section 1. Your protected health information may be used and disclosed by your physician, nurses, medical assistants, and our administrative office staff, as well as others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your

health care bills and to support the operation of your physician's practice.

Following are examples of the types of uses and disclosures of your protected health care information that the physician's office is permitted to make once you have signed our consent form. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office once you have provided consent.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you when we have the necessary permission from you to disclose your protected health information. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing and fund-raising activities, and conducting or arranging for other business activities.

For example, we may disclose your protected health information to medical assistants that assist in your care at our office. In addition, we may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Officer to request that these materials not be sent to you.

Use and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law, as described below. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Consent, Authorization or Opportunity to Object

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed. However, should you not consent to the use and disclosure of your protected health information for treatment, payment and healthcare operations; we will be unable to provide you medical services.

Facility Directories (Maryland Center for Digestive Health): Unless you object, we will use and disclose in our facility directory or schedule your name, the location at which you are receiving care, your physician, and your current discharge status (in general terms). All of this information will be disclosed to people that ask for you by name and inquire as to your discharge status.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary, if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Emergencies: We may use or disclose your protected health information in an emergency treatment situation. If this happens, your physician shall try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If your

physician or another physician in the practice is required by law to treat you and the physician has attempted to obtain your consent but is unable to obtain your consent, he or she may still use or disclose your protected health information to treat you.

Communication Barriers: We may use and disclose your protected health information if your physician or another physician in the practice attempts to obtain consent from you but is unable to do so due to substantial communication barriers and the physician determines, using professional judgment, that you intend to consent to use or disclosures under the circumstances.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object

We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the government entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or a company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the practice, and (6) medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity: Consistent with the applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military service. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Worker's Compensation: Your protected health information may be disclosed by us as authorized to comply with worker's compensation laws and other similar legally-established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care for you.

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. seq.

2. Your Rights

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A “designated record set” contains medical and billing records and any other records that your physician and the practice uses for making decisions about you.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician. You may request a restriction by requesting and completing the Protect Health Information Restriction Form from your physician’s staff.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for that request. Please make this request in writing to our Privacy Officer.

You may have the right to have your physician amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this

information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to our statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer, in writing, if you have any questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, for a facility directory, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. You may request a shorter time frame. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

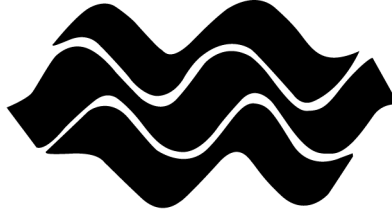
3. Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

You may contact our Privacy Officer,

**Gary M. Evans, Administrator
AAGA
171 Defense Highway
Annapolis, Maryland 21401**

for further information about the complaint process.
This notice was published and becomes effective on **April 14, 2003.**



Anne Arundel Gastroenterology Associates, P.A.

ACKNOWLEDGEMENT OF RECEIPT
OF THE AAGA NOTICE OF PRIVACY PRACTICES

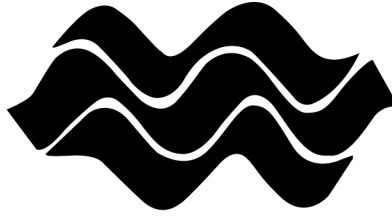
I, _____, hereby acknowledge that I have been offered and received a copy of the **Anne Arundel Gastroenterology Associates (AAGA), and its affiliate, Maryland Center for Digestive Health (MCDH)** Notice of Privacy Practices

Signature of patient or patient's representative

Date

Printed name of patient or patient's representative

Relationship to Patient



Anne Arundel Gastroenterology Associates, P.A.

**CONSENT FOR RELEASE OF INFORMATION FOR
TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS**

I, _____, hereby authorize (Consent) **Anne Arundel Gastroenterology Associates (AAGA), and its affiliate, Maryland Center for Digestive Health (MCDH)** to use and/or disclose my health information, which specifically identifies me or which can reasonably be used to identify me, to carry out my treatment, payment and health care operations. **I understand that while this consent is voluntary, if I refuse to sign this consent, AAGA and/or MCDH will be unable to treat me.**

I have been informed that AAGA and MCDH has prepared a notice ("Notice"), which more fully describes the uses and disclosures that can be made of my individually identifiable health information for treatment, payment and health care operations. I understand that I have the right to review such Notice prior to signing this Consent.

I understand that I may revoke this Consent at any time by notifying AAGA, in writing, but if I revoke my Consent, such revocation will not affect any actions that AAGA or MCDH took before receiving my revocation. Revocation of this Consent will result in the inability of AAGA or MCDH to provide care after the date of the revocation.

I understand that AAGA or MCDH has reserved the right to change his/her privacy practices and that I can obtain such changed Notice upon request.

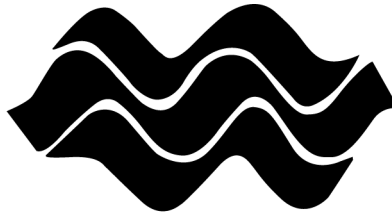
I understand that I have the right to request that AAGA or MCDH restricts how my individually identifiable health information is used and/or disclosed to carry out treatment, payment or health operations. I understand that AAGA or MCDH does not have to agree to such restrictions, but that once such restrictions are agreed to, AAGA or MCDH must adhere to such restrictions.

Signature of patient or patient's representative
(Patient's Name MUST be on form prior to signing)

Date

Printed name of patient or patient's representative

Relationship to Patient



Anne Arundel Gastroenterology Associates, P.A.

REQUEST FOR RESTRICTION ON THE USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____, request that AAGA accept the following restriction on the use and/or disclosure of my protected health information as described below.

I further understand that this is a request for restriction. As such. This request may not be accepted by AAGA. In the event the requested restriction is rejected, you will be notified in writing of the rejection and the reason for the rejection.

RESTRICTION REQUEST:

1. Restriction as to What Personal Health Information may be Used or Disclosed

I wish that the following information not be used or disclosed

2. Restrictions as to Who may Use or Disclose my Personal Health Information

I wish that the following individual, group of individuals, or entity not release any of my information, or the information specified in #1, above

3. Restrictions as to Whom my Personal Health Information may be released

I wish that my information, or the information specified in #1 above, not be released to the following individual, individuals, or entity

4. I understand that, if my protected health information is to be disclosed to someone who is not required to comply with the federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.
5. I understand that I have a right to revoke an accepted restriction at any time. My revocation of an accepted restriction must be in writing. The revocation notice must be sent in writing to the Privacy Officer, AAGA, 171 Defense Highway, Annapolis, Maryland 21401. I am aware that my revocation is not effective to the extent that the persons I have authorized to restrict the use and/or disclosure of my protected health information have acted in reliance upon this authorization.
6. This restriction, IF ACCEPTED BY AAGA, does not expire and once accepted it must be revoked by me in writing.
7. I understand that I must sign this restriction for it to be considered.
8. I certify that I have received a copy of the authorization.

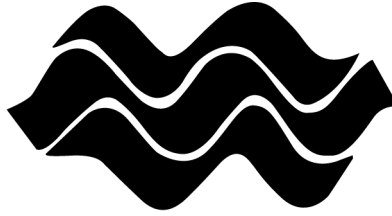
Patients Name/Persons Requesting Restriction(s)

Date

Accepted by Signature

Printed name of Person Agreeing to Requested Restriction

This request may only be accepted by the administration and Management of AAGA and will not be effective unless accepted by authorized management.



Anne Arundel Gastroenterology Associates, P.A.

**AUTHORIZATION FOR THE USE AND/OR
DISCLOSURE OF PROTECTED HEALTH INFORMATION**

I, _____, authorize the use and/or disclosure of my protected health information as described below:

1. My authorization applies to the information described below. Only this information may be used and/or disclosed pursuant to this authorization:

- | | |
|---|--|
| <input type="checkbox"/> Endoscopy Reports | <input type="checkbox"/> Medical Office Notes |
| <input type="checkbox"/> Colonoscopy Report | Please Specify Dates _____ |
| <input type="checkbox"/> Upper Endoscopy | |
| Please Specify Dates _____ | |
| <input type="checkbox"/> Medical Records | <input type="checkbox"/> Lab Reports, please specify |
| Please Specify Dates _____ | <input type="checkbox"/> Other, please specify _____ |

2. I authorize the following persons (or class of persons) to make the authorized use and/or disclosure of my protected health information:

3. I authorize the following persons (or class of persons) to receive my protected health information:

Name _____

Address _____

City/State/Zip _____

Relationship: _____

Reason for Release: _____

4. I understand that, if my protected health information is disclosed to someone who is not required to comply with the federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.

5. I understand that I have a right to revoke this authorization at any time. My revocation must be in writing. The revocation notice must be sent in writing to the Privacy Officer, AAGA, 171 Defense Highway, Annapolis, Maryland 21401. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.

6. This authorization does not expire. This authorization may only be revoked as noted in #5, above.

7. I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from Anne Arundel Gastroenterology Associates or Maryland Center for Digestive Health, nor will it affect my eligibility for benefits.

8. My protected health information will be used or disclosed upon request for the following purposes (please name and explain each purpose):

9. I understand that I have a right to inspect and copy my own protected health information to be used or disclosed, (in accordance with the requirements of the federal privacy protection regulations found under 45 C.F.R. §164.524).

10. I certified that I have received a copy of the authorization.

Patient's Name/Person Authorizing

Date

Accepted by Signature

Date

Printed name of Person Receiving Authorization