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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.

WHO WILL FOLLOW THIS NOTICE: This notice describes information followed by me or by any staff I may employ in the future. The “designated privacy officer” is Patrick Barta, M.D., Ph.D.

YOUR HEALTH INFORMATION: This notice applies to the information and records I have about your health, health status, and the healthcare and services you receive at this office.

HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU: I must have your written signed Consent to use and disclose health information for the following purposes:

1. **For Treatment.** I use health information about you to provide medical treatment or services. I may share information about you and disclose information to people who do not work in my office in order to coordinate your care, such as phoning/faxing prescriptions to you pharmacy and scheduling/ordering lab work. Family members and other healthcare providers outside this office may be part of you medical care and may require information about you that I have.
2. **For Payment.** I may use and disclose health information about you so that the treatment and services you receive at this office may be billed to and payment collected from you, an insurance company, or a third party. For example, I may need to give your health plan information about services you receive here so that they will pay me or reimburse you for services provided. I may also tell you health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.
3. **For Healthcare Operations.** If I hire additional staff, I may use and disclose health information about you to run the office and make sure you receive quality care, for example, to help with scheduling or billing.
4. **Appointment Reminders.** I may contact you as a reminder that you have an appointment at the office.
5. **Treatment Alternatives.** I may tell you about or recommend possible treatment options or alternatives that may be of interest to you.
6. **Health-Related Products and Services.** I may tell you about health-related products or services that may be of interest to you.

Please notify me if you do not wish to be contacted for appointment reminders, or if you do not wish to receive communications about treatment alternatives or health-related products and services. If you advise me that you do not wish to receive such communications, I will not use or disclose you information for these purposes.

You may revoke your Consent at any time by giving me written notice. Your revocation will be effective when I receive it, but it will not apply to any uses and disclosures that occurred before that time. If you revoke your Consent, I will not be permitted to use or disclose information for purposes of treatment, payment, or healthcare operation, and I may there fore choose to discontinue providing you with healthcare treatment.

TELEMEDICINE SERVICES: I offer telemedicine services to only to established patients whom I think would benefit from these services and who have a condition amenable to treatment by these means.

1. I verify your identity online by having met you before in a face to face evaluation.
2. All auditory or auditory-visual services involved with telemedicine are protected by online encryption to prevent access to your data by unauthorized persons.

SPECIAL SITUATIONS: I may use or disclose health information about you WITHOUT your permission for the following purposes, subject to all applicable legal requirements and limitations:

1. Prevention of a Serious Threat to Health or Safety. I may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of another person or the general public.
2. Required by Law. I will disclose health information about you when required to do so by federal, state, or local law.
3. Military, Veterans, National Security and Intelligence. If you are or were a member of the armed forces, or part of the national security or intelligence communities, I may be required by military command or other government authorities to release health information about you. I may also release information about foreign military personnel to the appropriate foreign military authority.
4. Worker's Compensation. I may release health information about you for workers' compensation or similar programs, but I would request your consent first.
5. Public Health Risks. I may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability, or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications, or problems with products. In Maryland, I must report any unreported and suspected child abuse which is occurring or has occurred at any time in the state of Maryland.
6. Health Oversight Activities. I may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the healthcare system, government programs, and compliance with civil rights laws.
7. Lawsuits and Disputes. If you are involved in a lawsuit or dispute, I may disclose healthcare information about you in response to a court or administrative order. Subject to all applicable legal requirements, I may also disclose health information about you in response to a subpoena.
8. Law Enforcement. I may also release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons, or similar process, subject to all applicable legal requirements.
9. Coroners, Medical Examiners and Funeral Directors. I may release health information to a coroner or medical examiner, for example, if necessary to identify a deceased person or determine the cause of death.
10. Information Not Personally Identifiable. I may use or disclose health information about you in a way that does not personally identify you or reveal who you are.
11. Family and Friends. I may disclose health information about you to your family member or friends if I obtain your written or verbal agreement to do so. I may also disclose health information to your family or friends if I can infer from the circumstances, based on my professional judgment, that you would not object, for example if you bring them into the office with you during treatment or when treatment is discussed. Please notify me of any specific issues that you do not want discussed in front of another person in such a situation. In situations where you are not capable of giving consent (because you are not present or due to your incapacity or medical emergency), I may, using my professional judgment, determine that a disclosure to your family member or friend is in your best interest. In that situation, I will disclose only health information relevant to that person's involvement in your care. I may also use my judgment to make reasonable inferences that it is in your best interest to allow another person to act on your behalf to pick up, for example, prescriptions or medical records.

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION

I will not use or disclose your health information for any purpose other than identified in the previous sections without your specific, written Authorization. I must obtain this Authorization separate from any Consent I may have obtained from you. If you give me Authorization to use or disclose health information about you, you may revoke that Authorization, in writing, at any time. If you revoke your Authorization, I will not longer use or disclose information about you for reasons covered by that written Authorization, but I cannot take back any uses or disclosures already made with your permission.

If I have medical information about you regarding HIV or substance abuse, I cannot release that information without a special signed, written Authorization (different from the Authorization and Consent mentioned above) from you. In order to disclose these types of records for purposes of treatment, payment, or healthcare operations, I will have to have both your signed Consent and a special written Authorization that complies with the law governing HIV or substance abuse records.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU: You have the following rights regarding health information I maintain about you:

1. Right to Inspect and Copy. You have the right to inspect and copy your health information, such as medical and billings records, that I use to make decisions about your care. You must submit a written request to me in order to inspect and/or copy your health information. If you request a copy, I may charge a fee for the costs of copying, mailing, or other associated supplies. I may deny the request to inspect or copy in certain limited circumstances. If you are denied access to your health information, you may ask that the denial be reviewed by a licensed psychiatrist. If such a review is required by law, I will comply with the outcome of the review.
2. Right to Amend. If you believe health information I have about you is incorrect or incomplete, you may ask me to amend the information. You have the right to request an amendment as long as I keep the information. To request an amendment, submit a Medical Record Amendment/Correction Form to me. I may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, I may deny your request if you ask me to amend information that I did not create (unless the person/entity who created the information is no longer available to make the amendment), that is not part of the health information I keep, that you would not be permitted to inspect and copy, or that is accurate and complete.
3. Right to an Accounting of Disclosures. You may request a list of the disclosures I made of medical information about you for purposes other than treatment, payment, and healthcare operations. To obtain this list, please submit your request to me in writing. It must state a time period which may not be longer than six years and may not start before November 16, 2003. Your request should state that you want the list in writing. I would notify you of the charge for the costs of providing the list so you may choose to withdraw or modify your request before any costs are incurred.
4. Right to Request Restrictions. You may request a restriction or limit on the health information I use or disclose about you for treatment, payment, or healthcare operations. You also may request a specific limit on the health information I disclose about you to someone who is involved in your care or the payment for it. I am not required to agree to your request, for example, if I think it will cause danger or harm to that person, but if I do agree, I will comply with your request unless the information is needed to provide you with emergency treatment. To request restrictions, please tell me. If necessary I will ask you to submit the Request for Restriction on Use/Disclosure of Medical Information to me.
5. Right to Request Confidential Communications. You may request that I communicate with you about medical matters in a certain way or at a certain way or at a certain location, for example, only at a certain phone number. To request confidential communications, please ask me. If necessary, I will ask you to submit the Request for Restriction on Use/Disclosure of Medical Information and/or Confidential Communication to me. I will accommodate all reasonable requests, but your request must specify how or where you wish to be contacted.
6. Right to a Paper Copy of this Notice. You may ask me for a copy of this notice at any time. To obtain one, please contact me.

CHANGES TO THIS NOTICE: I reserve the right to change this notice, and to make the revised or changed notice effective for medical information I already have about you as well as any information I receive in the future. I will post a summary of the current notice in the office with its effective date in the top right hand corner. You may request a copy of the current notice by contacting me.

COMPLAINTS: if you believe your privacy rights have been violated, you may file a complaint with me, with your insurance plan, or with the Secretary of the Department of Health and Human Services. To file a complaint with me, please contact me. You will not be penalized for filing a complaint.