NOTICE OF PRIVACY PRACTICES

This practice has implemented the following policies and procedures to ensure the confidentiality of your personal and/or medical information. Federal and state law require us to maintain the privacy of your health information.

Be assured that your physician and all other employees working in the practice will keep any information related to you (medical and/or non-medical) in a confidential manner at all times. However, so that we may provide you with appropriate medical care, we may at our reasonable discretion provide information pertaining to your medical treatment as requested by other health care related entities. This information would be submitted via: mail, phone, fax, voice mail and/or personal communications. The following are the most common types of these entities, but this list is not all–inclusive: 1) Your primary care and/or specialist physicians. 2) Medical facilities (i.e. hospitals, laboratories, pharmacies). 3) State or Federal agencies that require the submission of specific health related information.

We may need to contact you by phone (home, work or cell) to return your phone calls, and/or to discuss your appointment, test results, or treatments. If you are not available we will leave a message for you, worded as a generalized "doctor's office reminder of your appointment time," or as a request for you to call back for a non-detailed reason (i.e. "discuss test results").

At any time, you may request to review and/or obtain a copy of your medical record.

If you have any questions or concerns with the policies and/or procedures noted above, please contact us at 410-721-9862. We trust that you are comfortable with our sincere efforts to maintain the confidentiality of the information related to your medical care. You may change aspects of this consent at any time by giving us written notice. Finally, if you believe we have not maintained the privacy of your records, you may file a complaint with the Secretary of the US Department of Health and Human Services.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

The following person(s) are authorized to receive information about my care (i.e. messages, lab results, appointment times, etc.) and/or to pick up food products/prescriptions on my behalf.

Name: _____ Relationship: _____

I acknowledge the receipt of these policies and consent to their use relevant to the information in my medical records.

Patient Signature: _____ **Date:** _____

Print name:_____