

Washington Dermatology Center
7930 Old Georgetown Road
Bethesda, Maryland 20814

198 Thomas Johnson Dr
Frederick, Maryland 27102

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and ow you can get access to this information. Please review it carefully.

This notice takes effect on **APRIL 14, 2003** and remains in effect until we replace it.

1. OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. OUR LEGAL DUTY

Law Requires Us To:

- Keep your medical information private.
- Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
- Follow the terms of the notice that is now in effect.

We Have The Right To:

- Change our privacy practices and the terms of this notice at any time, provided that law permits the changes.
- Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices:

- Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may

also share medical information about you to other health care providers to assist them in treating you.

FOR PAYMENT: We may use and disclose your medical information for payment purposes to your Health Insurance Carrier.

FOR HEALTH CARE OPERATIONS: We may use and disclose your medical information for our health care operations. This might include measuring and improving quality of service and auditing accuracy of flow of Protected Health Information (PHI) in and out of our office

ADDITIONAL USES AND DISCLOSURES: In addition to using and disclosing your medical information for treatment, payment and healthcare operations, we may use and disclose medical information for the following purposes.

NOTIFICATION: Medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition, or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information for you.

Research in Limited Circumstances: Medical information for research purposes in limited circumstance where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.

Funeral Director, Coroner, and Medical Examiner: To help them carry out their duties, we may share the medical information of a person who has died with a coroner, medical examiner, funeral director or an organ procurement organization.

Court Orders and Judicial and Administrative Proceedings:

We may disclose medical information in response to a court circumstances under limited circumstances, such as a court order, warrant or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with law enforcement official concerning the medical information of a suspect or fugitive, material witness, crime victim or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

Public Health Activities: As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to track products or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

Victims of Abuse, Neglect or Domestic Violence: We may disclose medical information to appropriate authorities if we reasonable believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share information if it is necessary to prevent a serious threat to your health or safety or the health or safety of others.

Health Oversight Activities: We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities

Law Enforcement: Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises and crimes in emergencies.

4. YOUR INDIVIDUAL RIGHTS

You Have A Right To:

- Written Notice of Privacy Practices
- Request to review your medical records, and obtain copies for a nominal fee
- Request additional restrictions of your Protected Health Information (PHI).
- Request confidential communications of your Protected Health Information (PHI)
- Request an amendment to your Protected Health Information (PHI).
- Request an Accounting of certain disclosures of PHI
- File a privacy complaint to the Privacy Officer of Washington Dermatology Center.

If you have received this notice electronically and wish to receive a paper copy you have the right to obtain a paper copy by making a request to the Privacy Officer at our office.

5. QUESTIONS AND COMPLAINTS

If you have any questions about this notice or if you think that we may have violated your privacy rights, please our Privacy Officer. You may also submit a written complaint to the U.S. Department of Health and Human Services; we will provide you with the address to file your complaint with the U.S. Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint.

Acknowledgement Receipt Of Notice Of Privacy Practices

I acknowledge that I was provided on _____ by the Washington Dermatology Center a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the notice.

Patient Name (Please Print)

Patient Signature

Birth date

Parent or Authorized Representative (if applicable)

Request for Confidential Communications

Name of Patient: _____ Date of Birth _____

Name of Family Doctor: _____
(First & Last name required)

I request that all communications to me (by telephone, mail or otherwise) by Washington Dermatology Center and/or its staff are handled in the following manner:

- For **written** communication: Address To: _____

- For **oral** communications: Call _____

(Telephone number)

May we leave a message?

Yes

No

If the address provided above is not your home address or is a P.O. Box, please Provide us with a street address for purposes of ensuring payment.

Patient Signature

Date