COLON RECTAL SURGICAL ASSOCIATES, LLC

PRIVACY POLICIES

EFFECTIVE 4/14/2003

We are required by law to protect the privacy of your health information. This notice describes how medical information about you may be used and disclosed and how you can gain access to that information. Please read the document carefully and sign the bottom to acknowledge that you have received it.

The general consent for release of medical records that you sign authorizes Colon Rectal Surgical Associates to disclose the information in your medical record for treatment, payment and health care operations. Your information may be shared with: employees and contractors of this practice, with other health care providers who are treating you or consulting in your care, with your insurance company or other third party payors responsible for authorizing or paying for all or part of your care, and with our billing service to facilitate billing operations. We may be required by law to disclose records that you have not authorized such as when we receive a subpoena or for public health reasons. This information may be communicated in the following ways: mail, fax, Internet, phone/voice mail and personal communication.

We may need to contact you by phone to discuss appointments, test results, treatments, referrals, account balances or to return your phone call. We will attempt to contact you at home, but if necessary and if you have provided us with an alternate phone number, we will attempt to contact you at that number. If you are not available, we will leave a message for you to return the call, or to remind you of your appointment or the need for a referral. We will send statements or reminder notices to the home address that you provide us with at the time you registered with the practice. We may disclose your protected health information to your family or other individuals identified by you when they are involved in your care or the payment for your care.

If you would like information sent to another physician or medical facility, or if you would like us to release information to a life or disability insurer, you must authorize the release of this information in writing.

You have a right to inspect and/or obtain a copy of your medical record. You may request changes to be made to your medical records. You must make this request in writing with reasons that support your request. We will review your request and if we do not agree with the changes, you are entitled to have your statement added to your medical record. We must maintain a log of disclosures made by us except for disclosures made for treatment, payment and health care operations and you have a right to request a copy of this log.

We trust that you are comfortable with our sincere efforts to maintain the confidentiality of your medical record. If you believe that your rights have been violated, you may contact our Practice Administrator by phone (410-730-1712) or by mail (c/o Colon Rectal Surgical Associates, 4801 Dorsey Hall Drive, Ste 216, Ellicott City, MD 21042); or you may complain to the Secretary of the US Dept. of Health & Human Services. There will be no retaliation for making a complaint.

We reserve the right to change our privacy practices and to make new policies for protecting the health information of our patients. If we do so, we will issue an updated copy of the privacy policies to all of our patients. You make revoke any consent/authorization provided to us by giving **written notice**.

I, _____ acknowledge receipt of this privacy policy.

_____SEAL _____

Signature* Date

- I HAVE BEEN GIVEN THE OPPORTUNITY TO READ AND OBTAIN A COPY OF THE FULL DETAILED PRIVACY NOTICE.