NOTICE TO PATIENTS and GENERAL AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS FORM 2A

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

I, a patient of Annapolis Ear, Nose, Throat and Allergy Associates ("Provider"), understand that my signature below gives Provider permission, to the extent necessary, to use my medical record, and to provide access to my medical record, while and after I am treated by Provider, for the reasons that follow:

1. For the purpose of providing treatment to me. This would include, for example, sharing information with employees and contractors of Provider, or with other health care providers who are treating me or consulting in my care.
2. For the purpose of arranging payment for my care. This would include, for example, my insurer or other third-party payer who is responsible for paying all or part of the cost of my care.
3. For the purpose of Provider's "health care operations." This would include such things as internal quality assessment activities, contacting other health care providers regarding treatment alternatives, evaluating provider performance, training providers of care, legal and medical review of care provided, business planning and management, customer service, resolutions of internal grievances and the provision of legal and auditing services.
4. For the purpose of other health care providers' "health care operations"," to the extent that they have a treatment relationship with me

I understand that the Provider may be required by law, in some cases, to make disclosures of my record that I have not authorized. Examples are subpoenas in criminal or civil litigation, or requests/surveys by licensure agencies or the U.S. Department of Health and Human Services.

I understand that my permission allows Provider to transmit permissible information through any means that is reasonably secure, including via e-mail, assuming that reasonable protective measures are taken to preserve the confidentiality of the information.

I understand that I may revoke this authorization at any time, but that Provider may refuse to give me further treatment if I do so. I also may request a Specific Authorization for Release of Medical Records (Form 5) that I may sign that authorizes Provider to make a specific disclosure that is not covered under sections 1-4, above. A Specific Authorization will name the party to whom I am authorizing disclosure, and will contain any limitations on the authority to disclose my records.

I understand that I have the right to request that Provider restricts how my medical information is used. If I wish to request a restriction, I will initial the following box: ☐. In this case, Provider will give me a separate form to fill out (Form 4), which will also be used for Provider to indicate whether or not Provider agrees to the requested restriction. I understand that the Provider is not required to agree to restrictions not guaranteed by law. I understand that the Provider may contact me to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to me, including but not limited to voicemail messages, postcards or letters.

I understand that I have a number of rights identified below:

- The right to review, and receive a copy of my medical record. The Provider is entitled to charge me a reasonable fee related to the cost of copying my records. (not to exceed Maryland Law codified in the Health-General Article 4-304(c)(3).) I also understand that according to Maryland Law, my Provider may only copy medical records that they have created or test results from testing they have requested.
- The right to request the amendment (changing) of my medical record, and if the Provider does not agree to my request, to note my objection in the medical record. (Form 6-7)
- The right to receive confidential communications of my health information and to direct the place and manner of communication.
- The right to grant or deny access to my record to others.
- The right to revoke, in writing, any consent that I provide for access to my record.
- The right to authorize Provider to give information about my care to relatives or close friends, to the extent of their involvement with my care or payment (Form 3).
- The right to review an accounting list of disclosures of my medical record/information made by the Provider. (Except for those disclosures that are made to me or with my specific authorization, that fall within the scope of Provider's "health care operations, " or disclosures made for payment or treatment purposes.) (Form 12)
- The right to receive a paper copy of this notice and authorization.

I understand that if I believe my privacy rights have been violated, I may complain to the Provider, or to the Secretary of U.S. Department of Health and Human Services. To complain to the Provider, please call and ask to speak with our designated Privacy Complaints Contact Person: Judy. The Provider will not retaliate in any way against a patient for making a complaint.

The provider may decide to change some of the above-stated policies, and I understand that I will be given a revised Notice if this occurs.
Please acknowledge receipt and review of this notice and authorization by signing below.

____   ____________________________
Name of Patient (printed)   Date

____
Signature of Patient or Legally responsible individual)

____   ____________________________
Witness   Date

Welcome to Annapolis Ear, Nose, Throat and Allergy Associates,
the practice of Drs. Juan M. Pardo, Gregg Heacock, J. Michael Pardo, Joydeep Som and Matthew Hilburn.

As you have chosen our practice for your specialty care, please review the following policies of our office:

Insurance: Our physicians participate with many insurance plans. Participate means that we accept what the plan allows, however, the patient is still responsible for that portion allowed but not paid by the insurance company such as a deductible amount or co-pay. It is your responsibility as the patient to be informed about your insurance coverage. We may not be aware of rules unique to your group, such as where you need to have tests performed, what services are covered and when referrals are still valid.

Our office will submit your insurance claim for services rendered if you provide us with a valid insurance card at the time of visit. Please come prepared with your insurance card. We also require a copy of your driver's license for identification.

Co-payments and deductibles are due at the time of service. Please come prepared to make this payment. We accept cash (please do not bring large denominations of currency), checks and credit cards. For your convenience, we accept Visa and Master Card for amounts over $10. There is a $35 fee for returned checks.

Referrals: ***It is the patients' responsibility to obtain the proper referral PRIOR to his or her office visit.*** Please do not ask our office to obtain this referral for you or to request a referral after you arrive. You should either pick up your referral from the primary care or verify that it was sent or faxed to us and that we have received it, before the appointment time. Please do not ask to be treated without the proper referral, you will need to reschedule your appointment.

Appointments: If, for any reason, you cannot keep your appointment or need to cancel it, please call our office as soon as possible. We have a 24 hour cancellation policy and you will be charged $ 35.00 for any missed or not cancelled appointment.

Medical Records: Upon written request , signed by the patient or legal guardian, our office will send medical records directly to another physician at no charge. Patients may also receive a copy of their medical record. Copies of your medical record for legal reasons, obtaining insurance, or any other reason not noted above, may be obtained . Costs are established in accordance with Maryland Annotated Code and are subject to change. All requests for Medical Records will be processed as quickly as possible.

Acceptance and agreement:
I have read and accept the policies of this office. I hereby assume financial responsibility for and agree to make payment in full to Annapolis Ear, Nose, Throat and Allergy Assoc. for any and all charges received by me and/or my dependents not otherwise authorized or paid by my insurance carrier. I authorize the release of any medical information necessary to process my insurance claim forms and authorize payment of medical benefits to Annapolis Ear, Nose, Throat and Allergy Associates.

____ _________________________________ ____________________
Signature Relationship to patient Date

EMPLOYERS NAME ____

EMPLOYERS ADDRESS: ____

MEDICAL INFORMATION DISCLOSURE TO FAMILY/FRIENDS FORM 3

____ I do not want Annapolis Ear, Nose, Throat and Allergy Associates ("Provider") to disclose any information concerning my care, treatment or billing, or my child's (if applicable) to individuals without my express written consent or legal authorization.

____ I authorize Provider to disclose information related to my care and treatment, or my child's (if applicable) to the following named individual(s):

____

____ I authorize Provider to discuss information related to my bill with the following named individual(s):

____

___________________________________ ____ _________________
Patient Name (Printed) Signature of Patient (or legally responsible individual) Date

____ SCANNED TO PATIENT PERMANENT RECORD __________
Witness Date Date