

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU MAY OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Safeguarding Your Protected Health Information

Capital Digestive Care (“we” or “us”) is committed to protecting the privacy of medical information that we create or obtain about you. That information is referred to as “Protected Health Information” or “PHI.” PHI is information that identifies you and that we create or get from you or another health care provider, health plan, your employer or a health care clearinghouse and that relates to (1) your past, present or future physical or mental health or condition, (2) health care services that you received, or (3) the past, present or future payment for health care services that you received.

How We May Use and Disclose Your PHI

The following sections describe different ways that we may use and disclose your PHI. We abide by all applicable laws related to the protection of PHI. Not every use or disclosure will be listed. All of the ways we are permitted to use and disclose your PHI, however, will fall within one of the following categories:

Uses and Disclosures for Treatment, Payment and Health Care Operations

Treatment. We will use and disclose your PHI to provide you with medical treatment or services, to coordinate or manage your health care, or for medical consultations or referrals. For example, nurses, physicians and other members of your treatment team will record and use your PHI to determine the most appropriate course of care. We may also disclose your PHI to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, and to authorized family members who are helping with your care.

Payment. We will use and disclose your PHI so that the treatment and services you receive at Capital Digestive Care or from others may be billed to you and payment may be collected from you, an insurance company or another third party. For example, we may need to give information to your health insurance company about a visit at Capital Digestive Care so your health insurance company will pay us or reimburse you for the visit. We may also need to obtain authorization from your health insurance company before providing certain types of treatment.

Health Care Operations. We will use and disclose your PHI our health care operations. These uses and disclosures are made to enhance the quality of care that we provide, review the competence of our health care professionals, and general business activities. For example, we may disclose your PHI to doctors, nurses, technicians and others for review and education purposes

Special Uses

We may use your information to contact you with appointment reminders. We may also contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may contact you for fundraising purposes, but you have the right to opt out of receiving such communications.

We participate in Chesapeake Regional Information Systems for our Patients (CRISP), a regional health information exchange serving Maryland and D.C. As permitted by law, your health information will be shared with this exchange in order to provide faster access, better coordination of care and assist providers and public health officials in making more informed decisions. Refer to our Communications Notification form if you prefer to opt out of this program.

Other Uses and Disclosures

We may use or disclose your PHI for other reasons permitted or required by law, even without your authorization (permission), including:

Treatment Alternatives. We may use and disclose your PHI to tell you about, or recommend, possible treatment alternatives.

Our Services. We may use and disclose your PHI to inform you of health-related services, products or benefits that we may provide.

Fundraising. We may contact you to provide information about activities that we sponsor, including fundraising programs and events to support patient care at Capital Digestive Care. For this purpose, we may use your name and other limited information to contact you, including, the dates on which and the department from which you received treatment or services from us, your treating provider’s name, your treatment outcome, and your health insurance status. If we do contact you for fundraising activities, the communication you receive will have instructions on how you may ask for us not to contact you again for such purposes, also known as an “opt-out.”

Health Information Exchanges. We may share PHI that we obtain or create about you with other health care providers or other health care entities, such as your health plan or health insurer, as permitted by law, through Health Information Exchanges (“HIEs”) in which we participate. For example, information about your past medical care, current medical conditions, and medications can be available to us and your non-Capital Digestive Care physician or hospital if we participate in the same HIE. Exchange of PHI through HIEs can provide faster access, better coordination of care, and assist providers and public health officials in making more informed decisions. The purpose is so that each of your participating

health care providers can have the benefit of the most recent PHI available from other participating providers involved in your care. We participate in the Chesapeake Regional Information Systems for our Patients (“CRISP”), a regional health information exchange serving Maryland and D.C. As permitted by law, your PHI will be shared with CRISP in order to facilitate the secure exchange of your electronic PHI between health care providers and others for your treatment, payment, care coordination, or other health care operations purposes. Refer to our Communications Notification form if you prefer to opt out of this program.

Business Associates. We contract with third parties referred to as “business associates” to provide certain services on our behalf, such as billing and information technology. We may disclose your PHI to our business associates so they may perform the job we have asked them to do. To protect your PHI, we require our business associates to safeguard your information.

Required by Law. We may disclose your PHI when we are required to do so by federal, state or other law. For example, we may be required to report gunshot wounds, suspected abuse or neglect, or similar injuries and events.

Research. We may use or disclose your PHI for approved medical research.

Public Health Activities. As required by law, we may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.

Health Oversight. We may disclose your PHI to a health oversight agency for activities authorized by law, such as investigations, audits, inspections and licensure.

Judicial and Administrative Proceedings. We may disclose your PHI when ordered in a legal or administrative proceeding, such as a subpoena, discovery request, warrant, summons, court order, or other lawful process.

Law Enforcement Purposes. We may disclose your PHI to law enforcement officials for certain purposes authorized or required by law.

Deaths. We may disclose your PHI to coroners, medical examiners, funeral directors, and organ donation agencies as necessary for them to carry out their duties.

Serious Threat to Health or Safety. We may use and disclose your PHI when necessary to prevent or lessen a serious threat to your health and safety or the health and safety of the public or another person.

Military and Special Government Functions. If you are a member of the armed forces, we may disclose your PHI as required by military command authorities. We may also disclose your PHI to correctional institutions or for national security purposes.

Workers Compensation. We may disclose your PHI for workers’ compensation or similar programs providing benefits for work-related injuries or illness.

Written Authorization. Except as described above or as permitted by law, we will disclose your PHI only with your prior written authorization. Certain uses and disclosures of your PHI for marketing purposes and any sale of your PHI require your authorization. You may revoke that authorization in writing, at any time unless we have taken action relying on your prior authorization, or if you signed the authorization as a condition of obtaining insurance coverage.

The records of your PHI are the property of Capital Digestive Care. You have the following rights, however, with regard to the PHI that we maintain about you:

Right to Request Restrictions. You may request restrictions on certain uses and disclosure of your PHI. You have the right to restrict disclosures of your PHI to your health plan for payment and health care operations purposes (and not for treatment) if the disclosure pertains to a health care item or service for which you paid out-of-pocket in full. If requesting a restriction for a health care item or service for which you paid out-of-pocket in full, we will honor your request, unless the disclosure is necessary for your treatment or is required by law. For all other restriction requests, we are not required to agree to such restrictions.

Right to Request Confidential Communications. You may ask us to communicate with you confidentially by, for example, sending notices to a special address or not using postcards to remind you of appointments. We will honor reasonable requests. However, if we are unable to contact you using the requested ways or locations, we may contact you using information we have.

Right to Inspect and Obtain Copies. In most cases, you have the right to look at or get a copy of your PHI in our medical and billing records and in any of our other records that are used to make decisions about you. You have the right to request that we send a copy of your medical or billing records to a third party. We request that you submit your request in writing to your caregiver or the medical records department. We may charge you a reasonable fee for providing you with a copy of your

records. We may deny access under certain circumstances. You may request that we designate a licensed health care professional to review the denial. We will comply with the outcome of the review.

Right to Request an Amendment. If you feel that PHI we have about you is incorrect or incomplete, you may ask us to amend the PHI. You have the right to request an amendment for as long as the PHI is kept by or for us in your medical and billing records or any other of our records that are used by us to make decisions about you. You are required to submit your request in writing to the contact person listed at the end of this Notice, with an explanation as to why the amendment is needed. If we accept your request, we will tell you we agree and we will amend your records. We cannot change what is in the record. We add the supplemental information by an addendum. With your assistance, we will notify others who have the incorrect or incomplete PHI. If we deny your request, we will give you a written explanation of why we did not make the amendment and explain your rights. We may deny your request if the PHI (i) was not created by us (unless the person or entity that created the PHI is no longer available to respond to your request); (ii) is not part of the medical and billing records kept by or for us; (iii) is not part of the PHI which you would be permitted to inspect and copy; or (iv) is determined by us to be accurate and complete.

Right to Request Accounting of Disclosures. You have the right to receive a list of certain disclosures we have made of your PHI in the six years prior to your request. This list will not include every disclosure made, including those disclosures made for treatment, payment and health care operations purposes, or those disclosures made directly to you or with your authorization. You are required to submit your request in writing to the contact person listed at the end of this Notice. You must state the time period for which you want to receive the accounting. The first accounting you request in a 12-month period will be free, and we may charge you for additional requests in that same period.

Right to be Notified in the Event of a Breach. We will notify you if your PHI has been “breached,” which means that your PHI has been used or disclosed in a way that is inconsistent with law and results in it being compromised.

Right to Receive a Paper Copy of this Notice. You have the right to receive a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. Copies of this Notice will be available throughout our facilities, or by contacting the contact person listed at the end of this Notice, or you may obtain an electronic copy at our website at <https://www.capitaldigestivecare.com/hipaa-notice-of-privacy-practices/>.

We do not engage in selling your health information, however if we do, we will obtain your written authorization before we are permitted to sell your health information. In all other situations, including marketing activities, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

Future Changes to this Notice

We can change the terms of this Notice, and the changes will apply to all PHI we have about you. The new Notice will be available upon request, in our office, and on our website.

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about your records, you may contact the Privacy Officer at the location where you are receiving services. You also may send a written complaint to the U.S. Department of Health and Human Services. You will not be penalized in any way for filing a complaint.

Contact Person

If you have any questions, requests, or complaints, please contact:

Capital Digestive Care
ATTN: Privacy Officer
10770 Columbia Pike, Suite 400
Silver Spring, MD 20901

Contact us on the website at CapitalDigestiveCare.com or send an email to PatientRelations@capitaldigestivecare.com

I _____ (Print Name)
hereby acknowledge receipt of the Notice of Privacy Practices given to me.

Signed: _____

Date: _____

If not signed, reason why acknowledgement was not obtained: _____

Staff Witness: _____

Date: _____