Frederick T. Sutter, MD, LLC

Center for Wellness Medicine

NOTICE TO PATIENTS

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

A. The General Authorization for Release of Medical Records that you sign authorizes your medical care provider, Frederick T. Sutter, M.D., LLC ("Provider"), to disclose the information in your medical records to the extent needed for the following purposes:

1. For the purpose of providing treatment to you. This would include, for example, sharing information with employees and contractors of Provider, or with other health care providers who are treating you or consulting in your care.
2. For the purpose of arranging payment for your care. This would include, for example, your insurer or other third-party payor who is responsible for paying all or part of the cost of your 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.

B. A Specific Authorization for Release of Medical Records that you may sign authorizes Provider to make a specific disclosure that is not covered under section A, above. A Specific Authorization will name the party to whom you are authorizing disclosure, and will contain any limitations on the authority to disclose your records.

C. You may revoke any authorization provided to Provider by giving Provider a written notice of revocation. Provider may refuse to treat you if you revoke the General Authorization.

D. Provider may be required by law, in some cases, to make disclosures of your record that you 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.

E. Provider may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you

F. You have the following rights with respect to your medical records/information:

1. You have the right to request restrictions on the use and disclosure of your medical records/information; however Provider is not required to agree to restrictions not guaranteed by law. You will be informed if Provider will not agree to a requested restriction.
2. You have the right to receive confidential communications of your health information and to direct the place and manner of communication.
3. You have the right to inspect and copy your medical records. (Provider is entitled to charge you a reasonable fee related to the cost of copying your records).
4. You have the right to seek to amend your medical records, and if Provider does not agree with your request, to note your objection in the medical record.
5. You have a right to receive an accounting (list) of disclosures of your medical records/information made by Provider. (Except for those disclosures that fall within the scope of Provider's "health care operations" or disclosures made for payment or treatment purposes.)
6. You have the right to receive a paper copy of this notice.

G. Provider is required by law to maintain the privacy of protected health information, and to provide patients with this notice of its duties and practices, as well as changes to those practices.
Patients will be provided with revised notices, as appropriate.

H. If a patient believes that his or her privacy rights have been violated, the patient may complain to Provider, or to the Secretary of the U.S. Department of Health and Human Services. To complain to Provider, please write or call us with the details. Provider will not retaliate in any way against a patient for making a complaint.

I. If you as a patient or guardian believe that your privacy rights have been violated, and wish to notify our practice, please call our office and ask to speak with our designated **Privacy Complaints Contact Person**: **Katie Herring**

J. Provider reserves the right to change its privacy practices and to make its new policies effective for all protected health information that provider maintains. If such changes are made, Provider will issue an updated "Notice to Patients" to all of Provider's patients.

GENERAL AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I, patient of Frederick T. Sutter, M.D., LLC ("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;
2. For the purpose of arranging for payment for my care; and
3. For the purpose of Provider's "health care operations." This last category includes 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, resolution of internal grievances and the provision of legal and auditing 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 understand that I have the right to request that Provider restricts how my medical information is used. If you wish to request a restriction, request a separate form to fill out. Your request will be reviewed and a return form will be completed in response to your request.

I understand that I have a number of rights identified below (and listed more fully on the Patient Notice provided to me by Provider):

* The right to review, and copy, my medical record.
* The right to request the amendment (changing) of my medical record.
* The right to grant or deny access to my record to others.
* The right to decide how information from my record will be conveyed to others.
* The right to complain about how my records are handled, to the Secretary of the U.S. Department of Health and Human Services, and to Provider.
* 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.
* The right to review a record of access to my medical record.
* The right to be notified following a breach of unsecured protected health information (PHI).
* The right to restrict certain disclosures of PHI to a health plan where I pay out of pocket **in full** for the health care item or service.
* The right for other uses and disclosures not otherwise described in the Notice of Privacy Practices (NPP) will be made only with authorization from me.
* The right that my authorization is required for the sale of PHI.
* The right that my authorization is required for marketing purposes, including subsidized treatment communications.

I understand that I have the right to either grant or deny access to my medical record, and that my specific written permission will be sought if access is requested for any reason not set forth above.

I understand that I may be contacted for fundraising purposes: however, I have the right to opt out of fundraising communications with each solicitation.

DISCLOSURE TO FAMILY/FRIENDS

____ I do not want Frederick T. Sutter, M.D., LLC ("Provider") to disclose any information concerning my care or treatment by Provider to individuals without my express written consent or legal authorization.

____ I authorize Provider to disclose information related to my care and treatment to the following named individual(s):

____ I authorize Dr. Sutter's office to phone my home to confirm any future appointments that I may have with his office.

____ I authorize Dr. Sutter's office to send promotional and informational emails to my email address: _____

_____ _____

_____ _____

_____ _____

The authorizations provided for above are subject to the following limitations or restrictions:

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_____

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 by signing below. For further information, please call Linda Showalter at (410)-224-4446.

_____
Patient Name (Printed)

_____ _____
Signature of Patient (or legally responsible individual) Date

_____ _____
Witness Date