NEW PATIENT - HEALTH HISTORY

Welcome to Ananda Medical Practice the practice of Leigh Vinocur, MD

Thank you for choosing us for your health care.

Name: _____

Address: _____

Contact: Cell Phone: _____ Another Phone: _____

May we email you? Yes or No

Email Address: _____

Date of Birth: _____ Age: _____

Height: _____ Weight: _____ Gender: _____

Emergency Contact

Name: _____ Relationship: _____ Phone: _____

Driver's License # _____

Medical Cannabis Certification #. _____

PLEASE STATE YOUR CURRENT HEALTH CONCERN(S)

(i.e. why did you make this appointment)

_____

_____

_____

_____

_

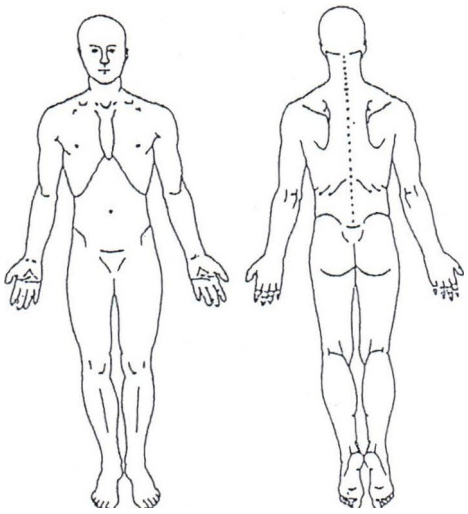
PAIN PATTERNS MAP

On the figures provided to the right, please "illustrate"
your areas of pain and/or numbness using the following key:

Moderate Pain = 0 0

Severe Pain = X X

Numbness/Tingling = N N



FOR YOUR MOST PRESSING HEALTH CONCERN, PLEASE DESCRIBE THE FOLLOWING:

What are the symptoms?

_____

_____

What makes it better, and what makes worse?

_____

_____

Does it interfere with your ability to function or sleep?
Please describe

_____

_____

When and how did this condition start?

_____

_____

What types of examinations have you had (doctors seen, tests performed, etc.)?

_____

_____

What treatments have you tried, and how well have they worked

_____

_____

PLEASE LIST YOUR CURRENT MEDICINES, SUPPLEMENTS, HERBS (w/ dosage):

_____

_____

PLEASE LIST ANY ALLERGIES (medications, food or environmental & your reactions):

_____

_____

Do you currently have a Primary Care Provider?

Name: _____ Phone # _____

What other medical providers are involved in your care?

Name: _____ Phone # _____

Name: _____ Phone # _____

CANNABIS HISTORY:

Are you currently using cannabis? YES NO

(If no, please skip to next section)

How? Please circle pipe, joint, vaporizer, tincture, edible, juicing, topical, concentrates, other:

_____

_____

How much cannabis do you use?

(eg 2 puffs twice daily, 1/4 ounce per week, 40 mg daily, etc):

_____

_____

Which strains work well, which don't?

_____

_____

How does cannabis help you?

_____

_____

Have you had any negative effects from cannabis?

_____

_____

MEDICAL HISTORY: Please list any other major health problems, hospitalizations, and surgeries that you had, and when:

_____

_____

_____

Please list any traumas you have experienced (accidents, falls, head injuries, abuse as a child, loss of loved ones, fires, abusive relationships, sexual assault, military combat, etc.):

_____

_____

_____

Have you been diagnosed with any of the following illnesses? (please circle)

Fibromyalgia, Chronic Fatigue Syndrome, POTS, Rheumatoid Arthritis, Lupus, Multiple Sclerosis, ALS, Bell's Palsy, Costochondritis, Transverse Myelitis, Idiopathic Neuropathy, Dementia.

Have you ever been bitten by a black legged (deer) tick?

_____

_____

Did you get a circular rash in the area of the bite?

_____

_____

Have you ever experienced a strong flu like illness in the summer or fall from which you never fully recovered?

_____

_____

Do you have any of the following symptoms (please circle)
Joint pain or swelling; Severe fatigue that is worse after activity; Numbness; Tingling; Radiating pain; Muscle or tendon aches; Pain in your ribs, chest, or between the shoulder blades; Swollen glands; Unexplained fevers, sweats, or chills; Unexplained lapses in memory, attention, concentration, or the ability to process numbers; Unprovoked mood swings; Feel like you've aged prematurely .

Do the above problems seem to come and go without a clear cause?
Yes or No

Have you noticed a pattern in the occurrence of these symptoms (e.g. monthly)?
Yes or No

Do the symptoms move around form one area of the body to another or switch sides?
Yes or No

Other Symptoms (Please circle any that you've empierced In the last 2 weeks):

GENERAL: Persistent fatigue; Weakness, Fever/chills; Dizzy; Fainting; Weight loss/gain

HEAD: Headaches; Eye pain; Trouble seeing; Trouble hearing; Ringing in ears; Ear pain; Stuffed nose; Tooth pain; Sore throat; Swollen glands

BRE ATHING: Cough; Excess phlegm; Bloody phlegm; Shortness of breath; Wheezing

HEART & CIRCULATION: Chest pains; Swollen ankles; Trouble breathing when laying down; Trouble walking upstairs; Legs cramp after walking; Heart races or skips beats

DIGESTIVE: Heartburn or reflux; Belly pain; Poor appetite; Nausea; Vomiting; Constipation; Diarrhea; Blood in vomit or stools; Black or tarry stools; Excess belching or passing gas; Rectal pain

URINARY: Pain or burning with urination; Frequent urination; Blood in urine; Decreased urine stream; Leaking urine

MUSCULOSKELETAL: Back pain; Painful muscles; Painful joints; Swollen joints; Morning stiff ness; Muscle cramps

NEUROLOGICAL: Radiating pain; Tingling; Numbness; Weakness; Blackouts; Tremors; Seizures; Trouble with balance or coordination; Memory changes

MENTAL HEALTH: Persistent sadness; Worry; Anxiety; Guilt; Fear; Paranoia; Over-energized; Trouble paying attention; Panic attacks; irritability; Flashbacks; Under-eating; Over-eating; Thinking about harming myself/ another

OTHER: Can't tolerate heat/ cold; Excessive sweating; Nipple leaking; Change in appetite/ thirst; Rash; Skin changes; Changed libido; Trouble or pain with sex

FOR WOMEN: Irregular bleeding; Problems with periods; Lumps in breasts; Vaginal dryness; Hot flashes

FOR MEN: Erection problems; Lumps or pains in testicles

FAMILY MEDICAL HISTORY:

Mother_____
Father_____
Siblings_____
Grandparents_____

LIFESTYLE AND SOCIAL LIFE:

How many cups or glasses do you drink per day?

Water: _____

Caffeinated Beverages: _____

What else do you drink: _____

How many alcoholic drinks do you have each day or week? _____

Tobaccos user? Yes or No

If yes, what do you use, how much and for how long:
_____
_____

How much and how often do you exercise, describe:

_____

_____

How many hours of sleep do you get each night? _____

Do you feel rested in the morning?

_____

Have you had any recent major life changes?

_____

What do you do for fun and relaxation?

_____

_____

With whom do you live?

_____

Do you feel safe at home? Yes or No
If no, why not?

_____

Are you Employed? Yes or No
If so, what do you do?

_____

WHAT ARE YOUR HEALTH AND HEALING GOALS? WHAT ARE YOUR GOALS FOR THIS VISIT?

_____

_____

_____

Patient Signature _____ Date: _____

Ananda Medical Practice
Patient Acknowledgement

I, _____ understand that: (Please initial next to each statement and sign as appropriate)

_____ I acknowledge that I have 120 days from the medical cannabis certification to buy the cannabis at a dispensary, otherwise, the certification will be null and void.

_____ I acknowledge that the use of cannabis affects coordination and cognition and impairs your ability to drive or engage in potentially hazardous activities.

_____ I acknowledge that cannabis potency varies with the strain and the method of consumption. Determining the appropriate cannabis dosage is difficult and may require a trial and error approach. Always start at the lowest dose and increase it gradually if needed.

_____ I acknowledge cannabis should not be used if pregnant or breastfeeding.

_____ I acknowledge possession of cannabis is still currently illegal under federal law. Dr Vinocur is not prescribing or dispensing cannabis; should she certify me, her certification is that a qualifying medical condition exists, and that the potential benefits of medical marijuana appear to outweigh the risks.

_____ I acknowledge the physician, staff and representatives of Ananda Medical Practice are addressing specific aspects of my medical care related to my use of marijuana as medicine under Maryland laws.

_____ I acknowledge that the provider is addressing specific aspects of a patient's medical care and are in no way establishing themselves as the primary care provider.

_____ I acknowledge that smoking cannabis within 1000 feet of a school, daycare, or public park is illegal.

_____ The attending physician, staff and or representatives of Ananda Medical Practice will NOT be providing or discussing information regarding dispensaries, co-ops, collectives, delivery services or any other way to obtain cannabis

_____Should an approval be made for my medicinal use of cannabis, there is a renewal date specified by the physician. It is my responsibility to arrange my appointment with the physician for a reassessment of my medical condition.

_____I acknowledge and represent that I am a resident of Maryland. If not a resident of Maryland, I understand that I am not going to be approved for medicinal use of cannabis and

will only have a consultation with the physician for educational purposes only.

_____I acknowledge and represent that I am over 18 years of age.

_____I acknowledge and represent that I am not an agent of law enforcement, state or federal government, here for the purpose of investigation or entrapment.

_____I acknowledge and represent that I am not recording any portion of my visit with Ananda Medical Practice nor do I possess any recording equipment on my person. I understand Ananda Medical Practice does not approve such action.

_____I understand there will be no refunds for fees paid for professional medical services.

_____I acknowledge and represent that all of the information I have provided to Ananda Medical Practice is true and correct and that I have not misrepresented any information to Ananda Medical Practice.

_____ I understand that the fee paid today is for professional medical services provided by Dr Vinocur. Emails and follow-up phone calls that are under 15 minutes are included in today' s fee if they occur during the period documented on the medical marijuana Physician's Statement. I understand that I will be required to pay an additional fee for any in-office follow-up visits with the Ananda Medical Practice physician and for phone calls with the Ananda Medical Practice physician that are over 15 minutes.

This Acknowledgement will be filed with my records.

_____ _____

Name Date

_____

Signature

Ananda Medical Practice Informed Consent

I,_____, {"Patient") am requesting Leigh Vinocur MD {"Physician") to certify, (*circle one)* me/my child/my legal ward, as a qualified patient, as defined by the Maryland Medical Cannabis Commission, and to treat Patient's debilitating medical condition as Patient uses marijuana for medical purposes. In requesting that Dr Vinocur continue treating Patient as Patient uses marijuana for medical purposes, I assume full responsibility for any and all risks of this action related to Patient's current medical condition.

I have been informed of and understand the following:
(Please initial next to each statement and sign as appropriate)

_____ I am being evaluated for a physician's recommendation for medical marijuana. The physician will make this recommendation based, in part, on the medical information I have provided. I have not misrepresented my medical condition in order to obtain this recommendation and it is my intent to use marijuana only as needed for the treatment of my medical condition, not for recreational or non-medical purposes. I understand that it is my responsibility to be informed regarding state and federal laws regarding the possession, use, sale/purchase and/or distribution of marijuana.

_____ I must be a Maryland resident to obtain an approval or recommendation for the use of (medical marijuana) under Maryland's Laws

_____ I understand the cultivation, distribution, possession, and use of marijuana is federally illegal. The federal government has classified marijuana as a Schedule I controlled substance. Schedule I substances are defined, in part, as having (I) a high potential for abuse; (2) no currently accepted medical use in treatment in the United States; and (3) a lack of accepted safety for use under medical supervision. Federal law prohibits the manufacture, distribution and possession of marijuana even in states, such as Maryland, which have modified their state laws to treat marijuana as a medicine.

_____I understand that the Food and Drug Administration has not approved marijuana for use as a treatment modality. I understand that marijuana for medical use is not subject to any standards, quality control, or other oversight. I understand that marijuana may contain unknown quantities of active ingredients, can vary in potency, and may contain impurities, contaminants, and unknown substances.

_____I understand that the use of marijuana can affect coordination, motor skills and cognition, i.e., the ability to think, judge and reason. While using marijuana, I will not drive, operate heavy machinery or engage in any activities that require me to be alert and/or respond quickly. I understand that if l drive while under the influence of marijuana, I can be arrested for "driving under the influence."

_____I understand that potential side effects from the use of marijuana include, but are not limited to, the following: dizziness, anxiety, confusion, sedation, low or high blood pressure, impairment of short-term memory, euphoria, difficulty in completing complex tasks, suppression of the body's immune system, inability to concentrate, impaired motor skills, paranoia, psychotic symptoms, general apathy, depression and/or restlessness. Marijuana may exacerbate schizophrenia in persons predisposed to that disorder. In addition, the use of marijuana may cause me to talk or eat in excess, alter my perception of time and space and impair my judgment.

_____ I understand that using marijuana and alcohol at the same time is not recommended. Additional side effects may become present when using both alcohol and marijuana.

_____ I agree to contact Emergency Medical Services or my primary care provider if I experience any of the side effects listed above, or if I become depressed or psychotic, have suicidal thoughts, or experience crying spells or respiratory problems. I will also contact my primary care provider if I experience changes in my normal sleeping patterns, extreme fatigue, increased irritability, or begin to withdraw from my family and/or friends.

_____ I understand that smoking marijuana may cause respiratory problems and harm, including chronic bronchitis, emphysema and laryngitis. Marijuana smoke is known to contain known carcinogens (chemicals that can cause cancer) and other harmful chemicals. Smoking marijuana may increase the risk of respiratory diseases and cancers in the lung, mouth and tongue. If I begin to experience respiratory problems when using marijuana, I will stop using it and report my symptoms to a physician.

_____ I understand that the risks, benefits and drug interactions of marijuana are not fully understood. If I am taking medication or undergoing treatment for any medical condition, I understand that I should consult with my treating physician(s) before using marijuana and that I should not discontinue any medication or treatment previously prescribed unless advised to do so by the treating physician(s).

_____I understand that individuals may develop a tolerance to, and/or dependence on, marijuana. I understand that if I require increasingly higher doses to achieve the same benefit or if I think that I may be developing a dependency on marijuana, I will contact the physician at Ananda Medical Practice.

_____I understand that signs of withdrawal can include: Feelings of depression, sadness, irritability, insomnia, restlessness, agitation, loss of appetite, trouble concentrating, sleep disturbances and unusual tiredness.

_____I understand that symptoms of marijuana overdose include, but are not limited to, nausea, vomiting, hacking cough, disturbances in heart rhythms, numbness in the hands, feet, arms or legs, anxiety attacks and incapacitation. If I experience these symptoms, I agree to contact the physician at Ananda Medical Practice immediately or go to the nearest emergency room.

_____I understand that If the physician or staff at Ananda Medical Practice subsequently learn that the information, I have furnished is false or misleading, the recommendation for marijuana may be revoked. I agree to promptly meet with the physician at Ananda Medical Practice and/or provide additional information in the event of any inaccuracies or misstatements in the information I have provided.

_____I have had the opportunity to discuss these matters with the physician and to ask questions regarding anything I may not understand or that I believe needed to be clarified.

_____I acknowledge that the physician at Ananda Medical Practice has informed me of the nature of a recommended treatment, including but not limited to, any recommendation regarding medical marijuana. I have been informed of the risks, complications and expected benefits of any recommended treatment, including its likelihood of success and failure. I acknowledge that I have been informed of alternatives to the recommended treatment, including the alternative of no treatment, and the risks and benefits. I, the undersigned, my heirs, assigns or anyone acting on my behalf, hold the physician, and his/her principals, agents and employees, free of and harmless from any liability resulting from the use of cannabis.

_____I understand that payment for services by this office is solely my responsibility, regardless of any Insurance coverage I may have I understand that it is necessary for Dr Vinocur to perform her assessment as required by Maryland law. I also understand that Dr Vinocur may recommend diagnostic testing and it is my responsibility to discuss this with my primary care or specialist provider.

This Consent will be filed with my records.

_____ _____

Name Date

_____

Signature

Acknowledgement: Review of Notice of Privacy Practices and Authority to Release Information

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices for Ananda Medical Practice. I understand that I may obtain additional copies upon request, as described in the Notice.
Please Initial: _____

I authorize Leigh Vinocur MD to review and discuss my medical information with the following individual(s): (leaving blank will only allow us to speak with you directly)

Full Name_____Relationship_____

Full Name_____Relationship_____

I authorize the physician to confirm my certification upon being contacted for verification by law enforcement, dispensaries and/or caregivers. I release the physician from claims for breach of privacy for so confirming. A verification request may occur through phone, mail, and/or internet.

_____

Signature of Patient, Parent or Guardian Date

In the event this request is made by the individual ' s personal representative

_____

Signature of Patient, Parent or Representative Date

_____

Legal Authority of Personal Representative

This Acknowledgement will be filed with my records.

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. You may request a revised version by accessing our website, or calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

1. Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office who are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of your physician's practice.

Following are examples of the types of uses and disclosures of your protected health information that your physician's office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with another provider. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used and disclosed, as needed, to obtain payment for your health care services provided by us or by another provider. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, fundraising activities, and conducting or arranging for other business activities.

We will share your protected health information with third party "business associates" that perform various activities (for example, billing or transcription services) for our practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. You may contact our Privacy Officer to request that these materials not be sent to you.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Agree or Object.

We may use or disclose your protected health information in the following situations without your authorization or providing you the opportunity to agree or object. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, if required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. For example, a disclosure may be made for the purpose of preventing or controlling disease, injury or disability.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable
federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration for the purpose of quality, safety, or effectiveness of FDA-regulated products or activities including, to report adverse events, product defects or problems, biologic product deviations, to track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), or in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of our practice, and (6) medical emergency (not on our practice's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: We may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally-established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization:
Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your protected health information for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures already made with your authorization.

Other Permitted and Required Uses and Disclosures That Require Providing You the Opportunity to Agree or Object:

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest.

Facility Directories: Unless you object, we will use and disclose in our facility directory your name, the location at which you are receiving care, your general condition (such as fair or stable), and your religious affiliation. All of this information, except religious affiliation, will be disclosed to people that ask for you by name. Your religious affiliation will be only given to a member of the clergy, such as a priest or rabbi.

Others Involved in Your Health Care or Payment for your Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

2. Your Rights

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you for so long as we maintain the protected health information. You may obtain your medical record that contains medical and billing records and any other records that your physician and the practice uses for making decisions about you. As permitted by federal or state law, we may charge you a reasonable copy fee for a copy of your records.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and laboratory results that are subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Officer.

You may have the right to have your physician amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for so long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you if you authorized us to make the disclosure, for a facility directory, to family members or friends involved in your care, or for notification purposes, for national security or intelligence, to law enforcement (as provided in the privacy rule) or correctional facilities, as part of a limited data set disclosure. You have the right to receive specific information regarding these disclosures that occur after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

3. Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

You may contact your doctor if you have any other questions about privacy practices.