DR. DOUGLAS C. McCORKLE, M.D., P.A.

NOTICE OF PRIVACY PRACTICES

EFFECTIVE APRIL 14, 2003

This notices describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Our Commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following important information:

Understanding your health record

A record is made each time you visit a hospital, physician, or other health provider. Your symptoms, examination and test results, diagnoses, treatment and a plan for future care are recorded. This information is most often referred to as your "health or medical record" and serves as a basis for planning your care and treatment. It also serves as a means of communication among any and all other health professionals who may contribute to your care.

Understanding your health information rights

Your health record is the physical property of the health care practitioner or facility that compiled it but the consent is about you and therefore, belongs to you. You have the right to request restrictions on certain uses and disclosures of your information and to request amendments be made to you health record information and to be given an account of all disclosures. You may request communication of your health information to be made by alternative means or to alternative locations. Other than activity that has already occurred, you may revoke any further authorizations to use or disclose your health information.

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are required by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or to the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs

Your rights regarding your health information

1. Communications: You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For example, you may ask that we contact you at home, rather than at work.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Adrain Sherd, Practice Administrator, Dr. Douglas C. McCorkle, M.D., P.A., 10 Crossroads Drive, Suite 100, Owings Mills, MD 21117, (410) 363-7172.
4. You may ask to amend you health information if you believe it is incorrect or incomplete and as long as the information is kept by or for our practice. You must provide us with a reason that supports your request for amendment and send written request to Adrain Sherd, Practice Administrator at above address.
5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices and may ask for one at any time. To obtain, this copy, contact our front desk receptionist.
6. Right to file a complaint: If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Adrain Sherd, Practice Administrator, 10 Crossroads Drive, Suite 100, Owings Mills, MD 21117, (410)363-7172. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Right to provide an authorization for other uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information policies, please contact Adrain Sherd, Practice Administrator, Dr. Douglas C. McCorkle, M.D., P.A., 10 Crossroads Drive, Suite 100, Owings Mills, MD 21117, (410) 363-7172.

Dr. Douglas McCorkle M.D., P.A.

Patient Acknowledgement Form

Use & Disclosure of Protected Health Information

The "Notice of Privacy Practices" for Dr. Douglas McCorkle, M.D., P.A. provides information about how we may use and disclose protected health information about you. Please acknowledge receipt of this office's Notice of Practices by initialing below:

_____
(Patient's initials)

Our Notice of Privacy Practices states that we reserve the right to change the terms described. Should this happen, you will receive a revised copy at your next office visit.

_____
(Patient's initials)

You have the right to request restriction on how your protected health information may be used or disclosed for treatment, payment, or health care operations. We are not required to agree to your restrictions, but if we do, we are bound by our agreement with you.

_____
(Patient's initials)

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in trust on your prior consent.

Patient Name If Minor—Parent/Legal Guardian Name

Signature of Patient/ Parent/Legal Guardian Date