

NOTICE OF PRIVACY PRACTICES

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

EFFECTIVE DATE OF THIS NOTICE

This notice went into effect on 4/4/2021

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

Under the Health Insurance Portability and Accountability Act of 1996 (hereafter, "HIPAA"), you have certain rights regarding the use and disclosure of your protected health information (hereafter, "PHI").

I. MY PLEDGE REGARDING HEALTH INFORMATION:

I understand that health information about you and your health care is personal. I am committed to protecting health information about you. I create a record of the care and services you receive from me. I need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this practice (Monsof LLC). This notice will tell you about the ways in which I may use and disclose health information about you. I also describe your rights to the health information I keep about you, and describe certain obligations I have regarding the use and disclosure of your health information.

I am required by law to:

- Make sure that PHI that identifies you is kept private.
- Give you this notice of my legal duties and privacy practices with respect to health information.
- Follow the terms of the notice that is currently in effect.
- I can change the terms of this Notice at any time, and such changes will apply to all the information I have about you. The new Notice will be available upon request and on my website (www.monsof.com).

II. HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

The following categories describe different ways that I use and disclose health information. For each category of uses or disclosures I will explain what I mean.

For Treatment Payment, or Health Care Operations: Federal privacy rules (regulations) allow health care providers who have direct treatment relationship with the patient/client to use or disclose the patient/client's personal health information without the patient's written authorization, to carry out the health care provider's own treatment, payment or health care operations. I may also disclose your PHI for the treatment activities to any health care provider. This too can be done without your written authorization. For example, if a medical provider were to consult with another licensed health care provider about your condition, we would be permitted to use and disclose your PHI, which is otherwise confidential, in order to assist the clinician in diagnosis and treatment of your health condition. I also use your PHI for operations purposes, including sending you appointment reminders, billing invoices and other documentation. The practice (Monsof LLC) engages third party service providers to work with us to administer and provide the service. These third party service providers will have access to your PHI solely for the purpose of performing services on our behalf.

Disclosures for treatment purposes are not limited to the minimum necessary standard. Because medical providers need access to the full record and/or full and complete information in order to provide quality care. The word “treatment” includes, among other things, the coordination and management of health care providers with a third party, consultations between health care providers and referrals of a patient for health care from one health care provider to another.

We will share the provider’s recommendation/PHI with the state agency: Maryland Medical Cannabis Commission in Maryland or the Virginia Board of Pharmacy in Virginia to communicate your recommendation for medical marijuana.

Lawsuits and Disputes: If you are involved in a lawsuit, I may disclose health information in response to a court or administrative order. I may also disclose health information about you or your minor child(ren) in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

III. CERTAIN USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION:

1. **Medical charts** I do keep medical charts and any use or disclosure of such charts require your Authorization unless the use or disclosure is:
 - a. **For my use in treating you which may include working with other companies or other medical providers to help with your treatment. Obtaining information from CRISP to help manage your treatment/recommendations. CRISP (Chesapeake Regional Information System) is a regional health information exchange. We participate with this exchange in order to assist your medical providers in making more informed decisions. You may opt-out and disable access to your health information available by calling 1-877-952-7477 or completing and submitting an opt-out form to CRISP by mail or through their website at www.crisphealth.org.**
 - b. **For my use in training or supervising medical practitioners to help them improve their skills. Or if the original medical provider that evaluated you requires a secondary opinion, is not available, off promise, has moved or terminated his/her employment.**
 - c. **For my use in defending myself in legal proceedings instituted by you.**
 - d. **For use by the Secretary of the Department of Health and Human Services (HHS) to investigate my compliance with HIPAA.**
 - e. **Required by law and the use or disclosure is limited to the requirements of such law.**
 - f. **Required by law for certain health oversight activities pertaining to patient treatment.**
 - g. **Required by a coroner who is performing duties authorized by law.**
 - h. **Required to help avert a serious threat to the health and safety of others.**
 - i. **In connection a suspected crime in general or a crime against any person who works for us or about any threat to commit such a crime.**
 - j. **To protect and defend the rights, property, or safety of Monsof LLC/providers.**
 - k. **In connection with a business transaction, such as the sale of all or a portion of my business/practice (Monsof LLC), a merger, or a consolidation as required or allowed by law.**
 - l. **For use in a medical emergency.**
 - m. **Made to qualified personnel for research, audit or program evaluation.**
2. **Marketing Purposes.** I will not use or disclose your PHI for marketing purposes without your prior written consent. For example, if I request a review from you and plan to share the review publically online or elsewhere to advertise my services or my practice, I will provide you with a release form and HIPAA authorization. The HIPAA authorization is required in the instance that your review contains PHI (i.e., your name, the date of the service you received, the kind of treatment you are seeking or other personal health details). Because you may not realize which information you provide is considered “PHI,” I will send you a HIPAA authorization and request your signature regardless of the content of your review. Once you complete the HIPAA authorization, I will have the legal right to use your review for advertising and marketing purposes, even if it contains PHI. You may withdraw

this consent at any time by submitting a written request to me via fax or mail to my address of business. Once I have received your written withdrawal of consent, I will remove your review from my website and from any other places where I have posted it. I cannot guarantee that others who may have copied your review from my website or from other locations will also remove the review. This is a risk that I want you to be aware of, should you give me permission to post your review.

IV. USES AND DISCLOSURES THAT DO NOT REQUIRE YOUR AUTHORIZATION.

Subject to certain limitations in the law, I can use and disclose your PHI without your Authorization for the following reasons.

1. Appointment reminders and health related benefits or services. I may use and disclose your PHI to contact you to remind you that you have an appointment with us. I may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that I offer.
2. When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law.
3. For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone's health or safety.
4. For health oversight activities, including investigations.
5. For judicial and administrative proceedings, including responding to a court or administrative order or subpoena, although my preference is to obtain an Authorization from you before doing so if I am so allowed by the court or administrative officials.
6. For law enforcement purposes, including reporting crimes occurring on my premises.
7. To coroners or medical examiners, when such individuals are performing duties authorized by law.
8. For research purposes.
9. Specialized government functions, including, ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or counterintelligence operations; or, helping to ensure the safety of those working within or housed in correctional institutions.
10. For workers' compensation purposes. Although my preference is to obtain an Authorization from you, I may provide your PHI in order to comply with workers' compensation laws.
11. For organ and tissue donation requests.

V. CERTAIN USES AND DISCLOSURES REQUIRE YOU TO HAVE THE OPPORTUNITY TO OBJECT.

Disclosures to family, friends, or others: You have the right and choice to tell me that I may provide your PHI to a family member, friend, or other person whom you indicate is involved in your care or the payment for your health care, or to share you information in a disaster relief situation. The opportunity to consent may be obtained retroactively in emergency situations to mitigate a serious and immediate threat to health or safety or if you are unconscious.

VI. YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO YOUR PHI:

1. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask me not to use or disclose certain PHI for treatment, payment, or health care operations purposes. I am not required to agree to your request, and I may say "no" if I believe it would affect your health care.
2. The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full. You have the right to request restrictions on the disclosure of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full.

3. The Right to Choose How I Send PHI to You. You have the right to ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and I will agree to all reasonable requests.
4. The Right to See and Get Copies of Your PHI. Other than in limited circumstances, you have the right to get an electronic or paper copy of your medical record and other information that I have about you. Ask us how to do this. I will provide you with a copy of your record, or if you agree, a summary of it, within 30 days of receiving your written request. I may charge a reasonable cost based fee for doing so.
5. The Right to Get a List of the Disclosures I Have Made. You have the right to request a list of instances in which I have disclosed your PHI for purposes other than treatment, payment, or health care operations, or other disclosures, or for which you provided me with an Authorization. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. I will provide the list to you at no charge, but if you make more than one request in the same year, I will charge you a reasonable cost based fee for each additional request.
6. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right to request that I correct the existing information or add the missing information. I may say “no” to your request, but I will tell you why in writing within 60 days of receiving your request.
7. The Right to Get a Paper or Electronic Copy of this Notice. You have the right to get a paper copy of this Notice, and you have the right to get a copy of this notice by email. And, even if you have agreed to receive this Notice via email, you also have the right to request a paper copy of it.
8. The Right to Choose Someone to Act For You. If you have given someone medical power of attorney or if someone is your legal guardian, that person can make choices about your health information.
9. The Right to Revoke an Authorization.
10. The Right to File a Complaint. You can file a complaint if you feel I have violated your rights by contacting me using the information on page one or by filing a complaint with the HHS Office for Civil Rights located at 200 Independence Avenue, S.W., Washington D.C. 20201, calling HHS at (877) 696-6775, or by visiting www.hhs.gov/ocr/privacy/hipaa/complaints.

DATA SECURITY We incorporate commercially reasonable safeguards to help protect and secure your personal information. However, no data transmission over the internet, mobile networks, wireless transmission or electronic storage of information can be guaranteed to be 100% secure. Please note that we cannot ensure the security of any information you transmit to us and you use our service and provide us with your information at your own risk.

VII. CHANGES TO THIS NOTICE

I can change the terms of this Notice at any time, and such changes will apply to all the information I have about you. The new Notice will be available upon request and on my website.

By signing this form you are confirming the receipt of the Notice of Privacy Practice and that you have read and understand the privacy practice notice. By signing this form, you are authorizing the use/or disclosure of your PHI (Protected Health Information).