MY METRO MEDICINE

Notice of Privacy Practices

Effective April 15, 2013

This notice, and the accompanying "Practices Regarding Disclosure of Client Health Information", describe how health information about you may be used and disclosed, and how you can get access to your health information. The Notices are available for downloading at www.MyMetroMedicine.com, are available by request, and are given to all individuals receiving care. Please review this information carefully.

Understanding Your Health Record

A record is made each time you come to My Metro Medicine for a treatment or consultation. Your symptoms, the practitioner's judgments, and a plan of services are recorded. This record forms the basis for planning your care and treatment / consultation at future visits, and also serves as a means of communication among other health professionals who may contribute to your care. Understanding what information is retained in your record and how that information may be used will assist you to ensure it is accurate and make informed decisions about who, what, when, where, and why others may be allowed access to your health information.

Understanding Your Health Information Rights

Your health record is the physical property of My Metro Medicine, but the content is about you and belongs to you. You have the right to review or obtain a copy of your health record, either on paper or electronically, and to request that appropriate amendments be made to your health record. You have the right to request restrictions, to authorize disclosure of the record to others, and be given an account of those disclosures. Other than activity that has already occurred, you may revoke any further authorizations to use or disclose your health information. Should we need to contact you, you have the right to request communication by alternate means or to alternate locations.

Our Responsibilities

My Metro Medicine is required to maintain the privacy of your health information and to provide you with this notice of our privacy practices. We are required to follow the terms of this notice and to notify you if we are unable to grant your request to disclose or restrict disclosure of your health information to others. My Metro Medicine reserves the right to change its practices and promises to make an effort to notify you of any changes. Other than for the reasons described in this notice, My Metro Medicine agrees not to use or disclose your health information without your consent.

Additional Information or Problems

To receive addition information or report a problem, you may contact My Metro Medicine directly at contact@mymetromedicine.com. If you believe your privacy rights have been violated, you have the right to file a complaint with My Metro Medicine and/or with the U.S. Department of Health and Human Services with no fear of retaliation by My Metro Medicine.

Contact Information

My Metro Medicine
910 Seventeenth St., NW,
Suite 1020
Washington, DC 20006
202-505-2805

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Ave., SW
Room 509F, HHH Building
Washington ,DC 20201

I, the undersigned, hereby acknowledge receipt of and fully understand the *Notice of Privacy Practices* laid out above. If I am under 18 years of age, I am required to have a parent or guardian sign on my behalf.

_____

Printed Name of Client, Parent, and/or Guardian

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Signature of Client, Parent, and/or Guardian

_____

Date

MY METRO MEDICINE

Practices Regarding Disclosure of Client Health Information

Effective April 15, 2013

Your health information will be routinely used for treatment/ consultation, payment, and quality-monitoring, and your consent, or the opportunity to agree or object, is not required in these instances:

- *Treatment/Consultation*—Information obtained by your practitioner at My Metro Medicine will be entered in your record and used to plan the services provided to you. Your health information may be shared with others involved in your care or providing consultation about your services. Your practitioner's own expectations and those of others involved in your care may also be recorded.
- *Payment*—Your record will be used to receive payment for services rendered by My Metro Medicine. A bill may be sent to either you or a third-party payer with accompanying documentation that identifies you, your diagnosis and/or practitioner's impressions, and procedures performed.
- *Quality Monitoring*—My Metro Medicine staff will use your health information to assess the care you receive and compare the outcome of your care to others. Your information may be reviewed for risk management or quality improvement purposes in our efforts to continually improve the quality and effectiveness of the care and services we provide.

In addition, the following disclosures are required by law and do not require your consent:

- *Food and Drug Administration (FDA)*—My Metro Medicine is required by law to disclose health information to the FDA related to any adverse effects of food, supplements, products, and product defects for surveillance to enable product recalls, repairs, or replacements.
- *Worker's Compensation*—My Metro Medicine will release information to the extent authorized by law in matters of worker's compensation.
- *Public Health*—This office is required by law to disclose health information to public health and/or legal authorities to avert a serious threat to health or safety, to report communicable disease, injury, or disability, or to comply with mandated reporting requirements for tracking of birth and morbidity.
- *Law Enforcement*—As required under state or federal law, your health information will be disclosed to appropriate health oversight agencies, public health authorities, law enforcement officials, or attorneys:

  (1) In response to a valid subpoena; (2) In the event that a staff member or business associate of this office believes in good faith that one or more clients, workers, or the general public are endangered due to suspected unlawful conduct of a practitioner or violations of professional or clinical standards; (3) When a client is a suspected victim of abuse, neglect, or domestic violence.

It is My Metro Medicine's practice to consider the following as routine uses and disclosures for which specific authorization will not be requested. You have the right to request restrictions on these uses. Otherwise, My Metro Medicine will request authorization whenever disclosure of personal health information is necessary to parties other than those referenced here:

- *Business Associates*—Some or all of your health information may be subject to disclosure through contracts for services to assist My Metro Medicine in providing health care. To protect your health information, we require these Business Associates to follow the same standards held by this office through terms detailed in a written agreement.
- *Communications with Family*—Using best judgment, a family member, close personal friend identified by you, personal representative, or other persons responsible for your care may be notified or given information about your care to assist them in enhancing your well-being or to confirm your whereabouts.
- *Marketing and Fundraising*—My Metro Medicine may send information to you about treatment alternatives and other health-related benefits that you may find useful.

I, the undersigned, hereby acknowledge receipt of and fully understand the *Practices Regarding Disclosure of Client Health Information* laid out above. If I am under 18 years of age, I am required to have a parent or guardian sign on my behalf.

_____

Printed Name of Client, Parent, and/or Guardian

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Signature of Client, Parent, and/or Guardian

_____

Date