PATIENT FORM 1

CROSSROADS MEDICAL ASSOCIATES
NOTICE TO PATIENTS

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

A. The General Authorization for Release of Medical Records that you sign authorizes your medical care provider, Crossroads medical Associates ("Provider"), to disclose the information in your medical record 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 payer who is responsible for paying all or part of the cost of your case.
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 provision of legal and auditing services.
4. For the purpose of other health care providers' "health care operations," to the extent that they have a treatment relationship with you.

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 request/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 the right to receive and accounting (list) of disclosures that are made to you or with your specific authorization, that fall within the scope of the 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 an 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 the designated Privacy Complaints Contact Person: Pat Yowell

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.

Please acknowledge receipt and review of this notice by signing below. For further information, please call Pat Yowell at 410-997-5191

_____ _____

Name of Patient (Printed) Date

_____

Signature of Patient or Lawfully Authorized Representative

Effective Date:_____

PATIENT FORM 2

CROSSROADS MEDICAL ASSOCIATES

GENERAL AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I, patient of Crossroads Medical Associates ("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, including release of information to other health care providers with whom I already am in treatment;
2. For the purpose of arranging for payment for my care;
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.
4. For the purpose of other health care providers' "health care operations," to the extent that they have a treatment relationship with me.

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 I wish to request a restriction, I will initial the following box: [ ]
In this case, Provider will give me a separate form to fill out, which will also be used for Provider to indicate whether or not Provider agrees to the requested restriction.

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 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

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, or, in most cases, for the release of psychotherapy notes.

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.

_____

Name of Patient (Printed)

_____ _____

Signature of Patient (or legally responsible individual) Date

_____ _____

Witness Date

PATIENT FORM 3

CROSSROADS MEDICAL ASSOCIATES
DISCLOSURE TO FAMILY/FRIENDS
TREATMENT AUTHORIZATION

_____ I do not want Crossroads Medical Associates ("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 individuals:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

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

_____

TREATMENT AUTHORIZATION: I _____
Authorize medical treatment of myself or my minor child by physicians and staff at Crossroads Medical Associates.

NOTIFICATION AUTHORIZATION: I authorize Crossroads' physicians and staff to contact me at the following number for scheduling or to inform me of medical or laboratory test results: _____ I do ____do not____ authorize leaving the results of such tests at that number (e.g. on answering machine or voicemail). Additional instructions or restrictions:
_____

_____

_____
Patient Name (Printed)

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

_____ _____
Witness Date