



**Peninsula Endoscopy Center
Delmar, MD
410-896-9005**

NPP CONSENT

I acknowledge that Peninsula Endoscopy Center has provided me a copy of the Notice of Privacy Practice (NPP) and has made me aware that I have the right to review such notice prior to giving consent. Peninsula Endoscopy Center reserves the right to change the terms of the NPP as necessary.

NPP acknowledged _____ (please initial here)

AUTHORIZATION TO RELEASE MEDICAL RECORDS AND OWNERSHIP DISCLOSURE

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION: I hereby authorize PENINSULA ENDOSCOPY CENTER to release my diagnosis and other medical information to third parties in order to secure payment for services rendered by the Centers' physicians and other providers of healthcare services.

Under Maryland law, I have the right to contest a decision by an HMO or health insurer that a proposed or delivered health care service was not medically necessary. The law allows the Health Education and Advocacy Unit (HEAU) of the Office of the Attorney General to assist me in filing an internal grievance with the HMO or health insurer and allows me to externally appeal the final decision to the Maryland Insurance Administration (MIA). I may appeal the initial decision directly to the MIA if I can demonstrate a compelling reason not to file an internal grievance with the HMO or health insurer. A health care provider may also file internal grievance or external appeal on my behalf. By signing this form, I either wish to file an internal grievance or appeal, or I authorize a health care provider to file such a grievance or appeal. I understand that, as part of the HEAU assisting me with my internal grievance, or the MIA handling my external appeal, the HEAU or MIA will contact my HMO or health insurer for explanation as to its actions in connection with my internal grievance or external appeal, or an internal grievance or external appeal filed on my behalf. I further understand that the Maryland Insurance Administration may receive advice from medical experts or an Independent Review Organization (IRO) while determining whether to uphold or overturn the HMO or health insurer's decision that a health care service was not medically necessary. Throughout the grievance or appeal process, the confidentiality of my medical records will be maintained in accordance with Maryland and Federal law. I understand that if I have questions about the contents of my medical records to be released. I should contact my health care provider. I understand that my records may be used to develop general statistical information on grievances and appeals, and any statistical reports will not identify me or contain any identifying information. I am not authorizing the release of any information that would identify me to anyone not mentioned above. In the event I, or a provider on my behalf, file an internal grievance or an external appeal, I authorize the release of my medical records as follows: 1. I authorize the Attorney General and the Insurance Administration to obtain medical records and insurance information for the purpose of investigating my grievance or appeal. 2. I authorize the Attorney General to release my medical records to the Insurance Administration so that my appeal or grievance may be investigated, and authorize the Insurance Administration to release my medical records to the Attorney General so that my appeal or grievance may be investigated. 3. I authorize the Insurance Administration to release my medical records to the relevant HMO or health insurer, and/or the HMO's or health insurer's legal counsel for the purpose of investigating my grievance or appeal or handing any hearing which may result from such investigation. 4. I authorize the Insurance Administration to transfer my medical records to the Department of Health and Mental Hygiene if my grievance or appeal involves potential issues of quality of care so that the Department may conduct an investigation into these particular issues. 5. I authorize the Insurance Administration to release my medical records to medical experts who may assist the Insurance Administration with my grievance or appeal. This authorization related to appeals is valid for a period not to exceed 12 months from the date of my signature below.

PLEASE NOTE: All patients 18 and over must sign this consent form themselves, unless they have a legal guardian, personal representative or are incapacitated. If so, the signer must submit written proof of guardianship, representative or incapacity with this consent form.

PATIENT'S CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION (Applies to Medicare Patients Only): I hereby certify that the information given by me applying for payment under TITLE XVII and XIX OF THE Social Security Act of the third party payers is correct. I authorize any holder of medical or other information about me to release to Social Security Administration or carries any information needed for this or related Medicare claim. I hereby authorize Peninsula Endoscopy Center to use my 60 Lifetime reserve days Medicare coverage.

DISCLOSURE OF OWNERSHIP: I acknowledge that the following physicians have ownership interest in this Peninsula Endoscopy Center: Dr. Kota Chandrasekhara, Dr. George Galifianakis, Dr. John Routenburg, and Dr. Steven Turnamian.

PERSONAL VALUABLES: Patients are encouraged to leave all valuables and money at home. Peninsula Endoscopy Center shall not be responsible for the loss of or damage to any personal property the patient has brought into the Center inclusive of dentures and glasses.

I CERTIFY THAT I UNDERSTAND THE CONTENT OF THIS FORM AND ALL INFORMATION GIVEN TO PENINSULA ENDOSCOPY CENTER, INCLUSIVE OF INSURANCE INFORMATION, IS ACCURATE AND CORRECT. A PHOTOCOPY OF THIS DOCUMENT SHALL BE VALID.

IF MORE THAN ONE SIGNS THIS DISCLOSURE/AGREEMENT, THEIR LIABILITY SHALL BE JOINT AND SEVERAL.

SIGNED PATIENT

WITNESS

DATE