NOTICE OF PRIVACY PRACTICES *Effective March 14, 2025*

Viraj V Tirmal MD LLC

3905 National Drive, Suite 220, Burtonsville, Maryland 20866

Telephone: 240-389-1986

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

This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Treatment Options and Health-Related Benefits and Services. We may use and disclose your protected health information to inform you of treatment options or alternatives as well as certain products, benefits or services that may be of interest to you. We may also use and disclose your protected health information to provide you with information about payment for such products, benefits or services, including payment methods that might be available to you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay or procedure or treatment may require that your relevant protected health information be disclosed to the health plan or health insurance company or other third party payor.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of our physician practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you

of your appointment, leave voice message, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect or domestic violence, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, serious threat to health or safety, workers' compensation, inmates, and other required uses and disclosures. In addition, we may disclose protected health information to the business associates that we contract to provide services on our behalf, if the information is needed to perform such services. Examples include our using an outside transcription service to type physicians' dictated notes or a copy service we may use when making copies of your health record or billing service to do billing for us. So that your health information is protected, however, we require the business associates to agree in writing to appropriately safeguard your information. We may share information about you with family members, relatives and friends involved in your care or paying for your care. Whenever possible, we will allow you to tell us who these individuals are. However, in emergencies or in situations where you are unable to tell us who to share information with, we will use our professional judgment to only share information others need to know. We may also share information about you with a public or private agency during a disaster relief effort.

Our practice uses email, phone, and SMS messaging. By signing this form, you agree to receive SMS messages from Viraj V Tirmal MD LLC. SMS opt-in or phone numbers for the SMS are not shared with any third party or affiliate company for marketing purposes. This includes SMS messages for customer service and marketing (including promotions, events, new service notifications, appointment scheduling, appointment reminders, post-visit instructions, lab notifications, and billing notifications). Messages will state: "Message frequency varies. Message and data rates may apply. See privacy policy at https://www.tirmal-md.com/privacy-policy. Message HELP for help. Reply STOP to any message to opt out."

If you provide us with a home or email address, home/work/cell telephone number, or other contact information during any registration or administrative process we will assume that the information you provided us is accurate and that you consent to our use of this information to communicate with you about our services, your treatment, payment for service and health care operations. Your consent is not shared with third parties for marketing purposes. You are responsible to notify us of any change of this information. Please call (240) 389-1986 to update your contact preferences.

USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

We will not use or share your protected health information for reasons other than those described in this Notice unless you authorize us in writing. Without your authorization, we will not use or disclose your protected health information for marketing purposes or sell your protected health information.

There are also other federal and state laws that may further restrict our disclosure of certain protected health information (to the extent we maintain such information) that is deemed highly confidential. This may include information pertaining to: psychotherapy notes; alcohol and drug abuse prevention, treatment and referral; HIV/AIDS testing, diagnosis or treatment; sexually transmitted diseases; and genetic testing. Our intent is to meet the requirements of these more stringent privacy laws and we will only disclose this type of specially protected health information with your prior written authorization except when our disclosure of this information is permitted or required by law.

If you give us authorization to use or disclose protected health information for a purpose not described in this Notice, you may revoke the authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization. In the event that you are incapacitated or are otherwise unable to respond to our request for an authorization, (for example, if you are or become legally incompetent), we may accept an authorization from any person who is legally authorized to give such authorization on your behalf.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply and there may be limited exceptions)- whether in paper or electronic format, pursuant to your written request. You may request that we transmit the copy of your protected health information directly to another person, provided your request is in writing, signed by you, and you clearly identify the designated person and the address.

You have the right to request a restriction of your protected health information- by asking us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to your requested restriction except if you request that the physician not disclose protected health information to your health plan with respect to healthcare for which you have paid in full out of pocket.

You have the right to request to receive confidential communications- from us by alternative means or at an alternative location (for example, at work), provided you specify in writing how or where you wish to be contacted. We will accommodate reasonable requests.

You have the right to request an amendment to your protected health information- provided the request is in writing. You must tell us the reason for your request. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures- of your protected health information, except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations, or required by law, that occurred six years prior to the date of your request or prior to effective date of this Notice. Your request must be in writing and define the time period. If you request this accounting more than once in a 12-month period, we may charge you a reasonable fee as permitted by law.

You have the right to receive notice of a breach from us- if your unsecured protected health information has been breached.

You have the right to obtain a paper copy of this notice upon request- even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and to make the revised or changed notice effective for all protected health information that we maintain. We will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. We will not retaliate against you for filing a complaint.

Compliance Officer: Viraj Tirmal, MD; Telephone: 240-389-1986

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions about this notice, please ask to speak with our Compliance Officer in person or by phone.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Viraj V Tirmal MD LLC

3905 National Drive, Suite 220, Burtonsville, Maryland 20866

Telephone: 240-389-1986

We are required by State and Federal laws to inform you of how your protected health information is used or disclosed by us and your rights in this regard. We have created a Notice of Privacy Practices for this purpose.

We are asking you to sign this form to show that we offered you a copy of our Notice of Privacy Practices. By signing below, you are only acknowledging that you were offered or received a copy of our Notice of Privacy Practices.

ACKNOWLEDGMENT

I acknowledge that the Viraj V Tirmal MD LLC has offered or provided me with a copy of its Notice of Privacy Practices.

_____ _____

Name of Patient or Patient's Representative Signature of Patient or Patient's Representative

_____ _____

Date Relationship to Patient

Everything below this line is for office use only

I made a good faith effort to obtain a written acknowledgment of receipt of the Notice of Privacy Practice from the above-named Patient/Patient's Representative, but was unable to because the Patient/Patient's Representative:

- ☐ Declined to sign
- ☐ Unable to sign
- ☐ Other _____
  _____

_____ _____

Employee's Name Date

*****This form should be placed in the Patient's Medical Record*****