Patient Privacy Rights Notification

HIPAA
Health Insurance Portability and Accountability Act

Effective Date:_____

How We May Use and Disclose Your Medical Information: The following describes the different ways we may use and disclose your medical information.

1. **Treatment:** In order to treat you we may disclose information to others who are involved in your care or treatment.

2. **Payment:** In order to bill and collect payment for services you receive from us, we may use and disclose information to obtain payment from third parties that may be responsible for such costs such as insurance companies or family members. We may use your medical information in order to bill you directly for services and items.

3. **Health Care Operations:** To operate our business to ensure you receive quality care and to assure our organization is well run.

4. **Appointment Reminders & Test Results:** To remind you that you have an appointment or change an appointment we will use all daytime phone numbers supplied on the Patient Information form you completed.

5. **Treatment Alternatives:** To inform you of treatment alternatives and/or health related benefits and services that may be of interest to you.

6. **Fundraising:** We may use or disclose your demographic information, including name, address, age, gender, and date of birth, as well as dates of health service information, department of service, treating physician, outcome information, and health insurance status for fundraising purposes. With each fundraising communication you will be provided the opportunity to opt-out of receiving such communication and we will provide you with an opportunity to opt back in to receive such communication if you should choose to do so.

7. **Marketing:** To make a marketing communication to you that occurs in a face-to-face encounter with you; concerns, products or services of nominal value; however, we may disclose your health information for marketing purposes if we will receive direct or indirect financial remuneration not related to our cost of making the communication unless we receive your authorization to do so.

8. **Coroners. Medical Examiners. Funeral Directors:** As needed to carry out their duties required by law.

9. **Organ and Tissue Donation:** To organizations that handle organ and tissue procurement, banking or transplantation.

10. **Sale of PHI:** We will not sell your PHI to third parties. However, this does not include disclosure for public health purposes, research where we only receive remuneration for our cost to prepare and transmit the PHI, for treatment and payment purposes, for sale, transfer, merger or consolidation of our practice, for a business associate or its subcontractor to perform health care functions on our behalf, or for purposes as required or permitted by law.

11. **Required By Law:** When required by applicable law regarding crime or criminal conduct; warrant, summons, subpoena or legal process. If served with a legal subpoena for records (contains a release or records signed by you or verbal authorization obtained from you or your attorney of record or proof of service from the requesting party) we must honor the request.

12. **Public Health Activities:** To control disease, injury or disability; maintain vital records such as birth or death; cancer reporting; child abuse or neglect; exposure to communicable disease; drug reactions or FDA warnings; recalling devices or medications. To notify appropriate government agencies and authorities regarding potential abuse or neglect of an adult patient including domestic abuse if the patient agrees or we are required by law to do so. Under limited circumstances to your employer for related workplace injury or illness or medical surveillance.

13. **Research:** Subject to special approval process, information may be used on research projects or studies. The information will not leave our premises without your authorization.

14. **Serious Threats to Health or Safety:** To reduce or prevent a serious threat to your health and safety or that of another individual or the general public. We will only disclose to persons or organizations able to help prevent the threat.

15. **Specialized Government Functions:** If you are a member of the U.S. or foreign military forces (including veterans) and if required by appropriate military command authorities; or to federal officials for intelligence and national security.

16. **Workers Compensation:** Our organization will release your medical information for workers' compensation and similar programs to all parties as required by state and federal law.

Your Rights Regarding Your Medical Information: You have the following rights regarding the medical information that we maintain about you. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when necessary to treat you. In order to request a restriction on the use or disclosure of your medical information, you must make your request in writing to the address below.

Requesting Restrictions: The right to request a restriction on our use and disclosure of your medical information for treatment, payment, or healthcare operations. You have the right to limit our disclosure to individuals involved in your care or the payment for your care such as family members and friends. We will use all contact phone numbers and addresses listed on the Patient Information form unless you place a restriction. You may restrict disclosure to your health plan if you have paid for the service in full, and the disclosure is not otherwise required by law. This type of request for restriction will only be applicable to the particular service. You will have to request a restriction for each service thereafter. The request for restriction must be submitted in writing and sent to the address below.

Confidential Communications: The right to request how our organization communicates with you about your health and related issues in a particular manner or certain locations without stating a reason for your request. We will use all contact phone numbers and addresses listed on the Patient Information form unless you place a restriction. The request for restriction must be submitted in writing and sent to the address below.

Notification of a Breach: The right to be notified if there is a probable compromise of unsecured medical information within 60 days of the discovery of the breach.

Inspections and Copies: The rights to inspect and obtain paper or electronic copies of the medical information that may be used to make decisions about you, including medical records, billing records, but not including psychotherapy notes. In order to inspect or obtain records, you must submit the request in writing to the address below. If you would like an electronic copy of your health information, we will provide you with a copy in the form and format as requested as long as we can readily produce such information in the form requested. Otherwise, we will cooperate with you to provide a readable electronic form and format as agreed.

Amendment: The right to ask us to amend your medical information if you believe it is incorrect or incomplete and you may request an amendment for as long as the information is kept by or for our organization. You must provide us with a reason that supports your request. The reason for your request needs to be in writing to the address below. Also, we may deny the request if you ask us to amend information that is accurate and complete; not part of the information you are permitted to inspect and copy; not created by our organization, unless the individual or entity that created the information is not available to amend the information.

Accounting of Disclosure: The right to request an accounting of disclosures made of your medical information to entities with which you do not have an established relationship. In order to obtain an accounting, you must submit your request in writing to the address below. All requests may not be longer than 6 years and may not include dates prior to October 16, 2003. The first request in a 12 month period is free of charge. You may be charged for any additional lists requested in a 12 month period.

Right to File a Complaint: If you believe your rights have been violated, you may file a complaint with our organization or with the secretary of the Department of Health & Human Services. You will not be penalized for filing the complaint. All complaints must be submitted in writing at the address below.

Right to Provide an Authorization of Other Uses and Disclosures: Our organization will obtain your written authorization for uses and disclosures that are not identified by this notice or are not permitted by applicable law, such as the use and disclosure of HIV/ AIDS, sexually transmitted diseases, genetic information, mental or behavioral health, and drug/alcohol abuse. Any authorization you provide to us regarding the use and disclosure of your medical information may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your medical information for reasons described on the authorization. Of course, we will not be able to take back any disclosures that we have already made with your permission.

Right to Paper Copy of This Notice: You are entitled to receive a paper copy of this notice. You will be asked to sign an acknowledgment proving receipt of this Notice of Privacy Practices. A more detailed notice that contains examples is available upon request at the office listed below.

Right to Request Email Communication: You may request that we communicate with you via email. You may be asked to provide your email address for the sole purpose of sending you information about events, educational seminars, reminders about your questionnaire, etc. If you wish to not receive information from us via email you may decline to provide your email address. You may also ask to have your email address removed from our mailing list at any time by contacting our office.

If you have any questions regarding this notice, your privacy rights, or our privacy policies please contact:

Norman H. Anderson, M.D., P.A.
Dania Neveau - HIPAA Privacy Officer
Drew Anderson - HIPAA Compliance Officer
2020 SE 17th Street, Ocala, FL 34471
(352) 861-2400

AUTHORIZATION FOR THE RELEASE OF PRIVATE HEALTH INFORMATION (PHI)

While under the care of the physicians at Urology Institute of Central Florida, I hereby give authorization for the release of private health related information to the following authorized persons.

Physicians	Family Members (Relation)
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

This information may be given to the above mentioned people either by phone, fax or in person should the need arise for this information to be released for my proper care while a patient here. Should any unforeseen incident arise that I wish not to inform any or all of the above named persons, I will notify Urology Institute of Central Florida in writing of such names.

I authorize Urology Institute of Central Florida and staff to leave medical information pertaining to my care using the following methods and will assume responsibility to notify Urology Institute of Central Florida and staff whenever this information changes.

- ◯ Home Phone
- ◯ Work Phone
- ◯ Cell Phone
- ◯ Mail
- ◯ Home Phone Voice-mail
- ◯ Work Phone Voice-mail
- ◯ Cell Phone Voice-mail
- ◯ Post Card

Patient Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

Acknowledgment of Receipt

I understand that under the Health Insurance Portability and Accounting Ac of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the healthcare providers who may be involved in that treatment directly or indirectly
- Electronically exchange records with other healthcare providers and organizations
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as the business aspects of running the practice on a daily basis
- Access drug benefit coverage and medication history

I have read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent at any time except to the extent that you have taken action relying on this consent.

Patient Name:_____

Patient Signature:_____

Date:_____

Inability to Obtain Acknowledgment

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgment, describe in good faith efforts made to obtain the individual's acknowledgment and the reasons why the acknowledgment was not obtained.

UICFLA Rep. Signature:_____

Date:_____

UROLOGY INSTITUTE OF CENTRAL FLORIDA

Norman H. Anderson, M.D., P.A.

Dania Neveau - HIPAA Privacy Officer
2020 SE 17th Street, Ocala, FL 34471
(352) 732-0277