

HIPPA Notice of Privacy Practices  
Alaska South Central Urology Specialists  
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**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW CAREFULLY.**

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

**Uses and Disclosure of Protected Health Information:** Your protected health information may be used and disclosed by our office in the care and treatment for the purpose of providing healthcare services to you, provide information needed by insurance to process claims, 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 healthcare and any related services. This includes the coordination or management and of your healthcare with a third party. For example, we would disclose your protected health information might 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.

**Payment:** Your protected health information will be used as needed to obtain payment for our healthcare services. For example, obtaining approval for a hospital stay that may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission

**Healthcare Operations:** We may use or disclose, as needed, your protected health information in order to support the business activities of your physicians practice. These activities include, but are not limited to, quality assessment, employee review, and training of medical staff, licensing 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.

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 Disease, Health oversight: abuse or neglect. Food and Drug Administration requirements: legal proceedings, Law Enforcement: Coroners, Funeral Directors and Organ Donation: Research, Criminal activity, military activity and national security and Workers compensation. Required uses and disclosures: Under the law we must disclose to you and when required by the Secretary of the Department of Health and Human Services investigate or determine our compliance with the requirements of section 164.500.

Other permitted and required uses and disclosure **Will Be Made Only With Your Consent**, Authorization or Opportunity to object unless other required by law. You may revoke this 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.

**Your Rights:** Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in civil, criminal or administration action or proceeding, and protected health information that is subject to law prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment or healthcare operations. You may also request that any part of your protected health information no 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 restrictions apply.

Your physician is not required to agree to a restriction that you may request. If a physician believes it is in your best interest to permit use and disclosure of your protected health information will not be restricted, You the have the right to use another healthcare professional. You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternative i.e. electronically.

You have the right to receive an accounting of certain disclosures we have made, if any of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

**Complaints:** You may complain t 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 privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on or before April 14, 2003.

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. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at our main phone number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: \_\_\_\_\_ Singnature: \_\_\_\_\_ Date: \_\_\_\_\_