DESERT MOUNTAIN UROLOGY

NOTICE OF PRIVACY PRACTICES

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

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individual identifiable health information used or disclosed by us in any form, whether electronically, on paper, or verbally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for the use of the following purposes:

TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

- Treatment means providing, coordinating, or managing health care related services by one or more healthcare providers. An example of this would include a physical exam.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Health care operations include the business aspect of running our practice, such as conduction of quality assessment and improvement activities, auditing functions, and cost management analysis and customer service. An example of this would be an internal quality assessment review.

We may also create and distribute de-identified health information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except in the extent that we have already taken actions relying on your authorization.

Anthony Chavez, MD

5170 E Glenn St Suite 100, Tucson, AZ 85712 | Phone (520) 355-5111 | Fax (520) 844-6901

DesertMountainUrology.com

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NOTICE OF PRIVACY PRACTICES ACKNOWLEGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA") I have the right to privacy regarding my protected health information. I understand that this information will be used to carry out treatment.

I hereby acknowledge that I have been presented with a copy of Dr. Chavez's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information and my individual rights with respect to my protected health information.

I give my permission to disclose and release my protected health information to the individuals listed below. This health information may be used to enable the person(s) I authorize to know and understand my condition and my treatment or treatment options, for treatment or consultation, for claims payment purposes, or related reasons. This authorization shall remain in effect until otherwise notified. This authorization can be revoked in writing at any time by notifying our office.

Patient Signature: X _____ Date: _____

Patient Name: _____ DOB: _____

Name(s):	Relationship:	Phone:
_____	_____	_____
_____	_____	_____

O **At this time I do NOT give my permission to release my PHI to anyone but myself and my doctor (s).**

Office use:

I have attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Reason: _____ Staff Member: _____ Date: _____

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