NOTICE OF PRIVACY PRACTICES
SOUTHERN UROLOGY
(Includes Lafayette Diagnostic & Radiation Treatment Center)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA), requires all health records and other Protected Health Information ("PHI") used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential.

OUR LEGAL DUTY: We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice in its currently in effect was updated on 03/26/13 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the Company Contact information listed at the end of the Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION: Without specific written authorization, we are permitted to use and disclose your healthcare records for the purpose of TREATMENT, PAYMENT, HEALTH CARE OPERATIONS, and OTHER REASONS REQUIRED BY LAW:

TREATMENT: This means providing, coordinating, or managing health care and related services by one or more healthcare providers/physicians. For example, if your specialist asks your primary care doctor to share PHI related to any physical exams or diagnostic procedures done.

PAYMENT: This means such activities as obtaining reimbursement for services, confirming coverage, billing, or collection activities, and utilization review. An example of this would be billing your insurance company or Medicare for services rendered.

HEALTH CARE OPERATIONS: This is the business aspect of running our practice, such as conduction quality assessment and improvement activities, auditing functions, cost-management analysis and customer service. An example of this would be a periodic quality review/assessment of our documentation protocol, etc.

PUBLIC HEALTH, ABUSE or NEGLECT, HEALTH OVERSIGHT, and OTHER REASONS REQUIRED BY LAW: We will use and disclose your PHI when we are required to do so by federal, state or local laws. We may disclose your PHI to public health authorities that are authorized by law to collect information, or to a health oversight agency for activities included but not limited to: response to a court order or administrative order; if you are involved in a lawsuit or similar proceeding; response to a discovery request, subpoena, or other lawful process by another party involved in the dispute-- but only if we made an effort to inform you of the request or obtain an order protecting the information the party has requested. We may release your PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death or if you are an organ donor. We may release your PHI to the tumor registry. We may use and disclose PHI when necessary to reduce or prevent a serious threat to your health and safety, of another individual or to the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat. We may disclose your PHI if you are a member of the U.S. or foreign military (including veterans) when required for appropriate intelligence or national security activities authorized by law. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary for the institution to provide health care services to you, for the safety and security of the institution, and to protect your health and safety or that of other individuals or the public. We may release your PHI for worker's compensation and similar programs.

In addition, your confidential information may be used to remind you of an appointment (electronically, by mail, letters, voicemail messages, or postcards) or provide you with information about treatment options or other health related services including release of information to friends or family members that are *directly* involved in your care or assist in taking care of you.

PATIENT RIGHTS

AUTHORIZATION: Any uses or disclosures of your PHI *not* addressed above may only be made with your authorization. You may revoke such authorization in writing and we are required to honor and abide that written request, except to the extent that we have already taken actions relying on your authorization.

ACCESS: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to your physician to obtain access to your health information. We will charge you a reasonable cost-based fee for expenses such as copies, electronic media storage, and staff time.

RESTRICTIONS: The following uses and disclosures will be made only with your authorization: (i) most uses and disclosures of psychotherapy notes; (ii) uses and disclosures of PHI for fundraising or marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this NPP.

ADDITIONAL RESTRICTIONS: You have the right to request additional restrictions on our use or disclosure of your health information. This must be made in writing, and must identify: (i) the information to be restricted; (ii) the type of restriction being requested (i.e. on the use of information, the disclosure of information, or both); and (iii) to whom the limits should apply. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

RESTRICTING DISCLOSURE TO YOUR INSURANCE COMPANY: We must comply with your restriction request if you have paid for your services out-of-pocket, in full, and you are requesting that we not disclose your PHI related solely to those services to your health plan. This request must be made in writing prior to or on the date of the service to allow our office to provide you with the information on your out of pocket cost, collect necessary fees for service, obtain a signature of this request, and avoid filing to your insurance.

DISCLOSURES OF ACCOUNTING: You have the right to receive a list of instances in which we, or our business associates, disclosed your health information for purposes other than treatment, payment, healthcare operations and other reasons required by law herein, for the last 6 years. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

ALTERNATIVE COMMUNICATION: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. Your request must be in writing and specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

AMENDMENT: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

ELECTRONIC NOTICE: If you receive this Notice on our Website, you are entitled to receive this Notice in written form.

BREACH: We are required to notify you if there is a breach and/or unauthorized use of your PHI.

QUESTIONS AND COMPLAINTS: If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights or you disagree with a decision we made about access to your health information, you may contact the person below. You may also submit a written complaint to the U.S. Department of Health and Human Services.

We support your rights to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

CONTACTS:

Company's Contact:
Mark Eldredge
120 Rue Louis XIV
Lafayette, LA 70508
PHONE: 337-769-7779
FAX: 337-769-7788

Government Contact:
U.S. Dept. of Health & Human Services
Office of Civil Rights
200 Independence Ave. S.W.
Washington, D.C. 20201
Toll Free 877-696-6775

Revised on 04/26/2013

Southern Urology, LLC

PRIVACY NOTICE ACKNOWLEDGMENT

I hereby acknowledge that I have been given the opportunity to read and review Southern Urology's Notice of Privacy Practices, located on our web site and in the lobby of each Southern Urology office. I understand that a copy of this Notice will be made available to me, for my personal use, if requested.

_______________________________ _______________________________
Patient's Name (Please Print) Date of Birth

_______________________________ _______________________________
Patient/Representative **Signature** Date of Signature

____
Representative's Relation to Patient, If Applicable

Documentation of Good Faith Effort

(To be completed by Southern Urology Staff if a signature is not obtained by patient or representative)

A good faith effort has been made to obtain a written acknowledgement of the Notice of Privacy Practices made available to the patient, provided in the lobby of our office. An Acknowledgement has not been obtained because:

☐ Patient refused to sign the Acknowledgement despite having opportunity to read and review.

☐ Other: Patient was unable to sign the acknowledgement because:_______________________________
____

_____________________________________ ____________________
Employee Signature Date