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## NOTICE OF PRIVACY PRACTICES

**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.**

### OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your Individually Identifiable Health Information (IIHI). 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 is effective **as of August 1, 2013** and will remain in effect until we replace it.

All of the employees of North Central Texas Urology (NCTU) have read and signed a *Confidentiality Statement*. This document requires all employees who have access to Individually Identifiable Health Information (IIHI) to maintain all IIHI in a confidential manner as directed by law and by the Privacy Policies of this practice.

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. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available to patients upon request.

You may request a paper 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 information listed at the end of this Notice.

### TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

**Treatment:** We are permitted to use and disclose your medical information to those involved in your treatment. For example, the physician in this practice is a Specialist. When we provide treatment, we may request that your primary care physician share your medical information with us. Also, we may provide your primary care physician information about your particular condition so that he or she can appropriately treat you for other medical conditions, if any. You may elect to fill out a *Patient Authorization for Personal Representative Form*, which provides for a person you name to have access to your Individually Identifiable Health Information. Unless this form is completed by you, North Central Texas Urology will comply with the privacy practices in this Notice regarding your Individually Identifiable Health Information.

**Payment:** We are permitted to use and disclose your medical information to bill and collect payment for the services we provide to you. For example, we may complete a claim form to obtain payment from your insurer. This form will contain medical information, such as a description of the medical services provided to you that your insurer needs to approve payment to us.

**Health Care Operations:** We are permitted to use or disclose your medical information for the purposes of health care operations, which are activities that support this practice and ensure that quality care is delivered. For example, we may engage the services of a professional to aid this practice in its compliance programs. This person will review billing and medical files to ensure we maintain our compliance with regulations and the law.

**Business Associates:** In order to provide services to our patients, a Business Associate may come into contact with patient and/or employee's IIHI. For this reason, we have required Business Associates to sign a *Business Associate Agreement* acknowledging and agreeing to follow all of the Privacy Practices of North Central Texas Urology as required by federal and state law.

## **DISCLOSURE THAT CAN BE MADE WITHOUT YOUR AUTHORIZATION**

There are situations in which we are permitted to disclose or use your medical information without your written authorization or an opportunity to object. In other situations, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization, in writing, to stop future uses and disclosures. However, any revocation will not apply to disclosures or uses already made or that rely on that authorization.

**Public Health, Abuse or Neglect, and Health Oversight:** We may disclose your medical information for public health activities. Public health activities are mandated by federal, state, or local government for the collection of information about disease, vital statistics (like births and death), or injury by a public health authority. We may disclose medical information, if authorized by law, to a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition. We may disclose your medical information to report reactions to medications, problems with products, or to notify people of recalls of products they may be using.

Because Texas law requires physicians to report child abuse or neglect, we may disclose medical information to a public agency authorized to receive reports of child abuse or neglect. Texas law also requires a person having cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation, report this information to the state. HIPAA privacy regulations permit the disclosure of information to report abuse or neglect of elders or the disabled.

We may disclose your medical information to a health oversight agency for those activities authorized by law. Examples of these activities are audits, investigations, licensure applications and inspections, which are all government activities undertaken to monitor the health care delivery system and compliance with other laws, such as civil rights laws.

**Legal Proceedings and Law Enforcement:** We may disclose your medical information in the course of judicial or administrative proceedings in response to an Order of the court (or the administrative decision-maker) or other appropriate legal process. Certain requirements must be met before the information is disclosed.

If asked by a law enforcement official, we may disclose your medical information under limited circumstances provided:

- The information is released pursuant to legal process, such as a warrant or subpoena;
- The information pertains to a victim of crime and you are incapacitated;
- The information pertains to a person who has died under circumstances that may be related to criminal conduct;
- The information is about a victim of crime and we are unable to obtain the person's agreement;
- The information is released because of a crime that has occurred on these premises; or
- The information is released to locate a fugitive, missing person, or suspect.

We may also release information if we believe the disclosure is necessary to prevent or lessen an imminent threat to the health or safety of a person.

**Workers' Compensation:** We may disclose your medical information as required by workers' compensation law.

**Inmates:** If you are an inmate or under custody of law enforcement, we may release your medical information to the correctional institution or law enforcement official. This release is permitted to allow the institution to provide you with medical care, to protect your health or the health and safety of others, or for the safety and security of the institution.

**Military, National Security and Intelligence Activities, Protection of the President:** We may disclose your medical information for specialized governmental functions such as separation or discharge from military service, requests as necessary by appropriate military command officers (if you are in the military), authorized national security and intelligence activities, as well as authorized activities for the provision of protective services for the president of the United States, other authorized government officials, or foreign heads of state.

**Research, Organ Donation, Coroners, Medical Examiners, and Funeral Directors:** When a research project and its privacy protections have been approved by an institutional review board or privacy board, we may release medical information to researchers for research purposes. We may release medical information to organ procurement organizations for the purpose of facilitating organ, eye, or tissue donation if you are a donor. Also, we

may release your medical information to a coroner or medical examiner to identify a deceased person or a cause of death. Further, we may release your medical information to a funeral director when such a disclosure is necessary for the director to carry out his duties.

**Required by Law:** We may release your medical information when law requires the disclosure.

### **YOUR RIGHTS UNDER FEDERAL LAW**

The U.S. Department of Health and Human Services created regulations intended to protect patient privacy as required by the Health Insurance Portability and Accountability Act (HIPAA). Those regulations create several privileges that patients may exercise. We will not retaliate against patients who exercise their HIPAA rights. **You have the right to inspect and copy your Individually Identifiable Health Information.** This means you may request inspection or copying of your IIHI for as long as we maintain the IIHI. When requesting a copy of your IIHI, you will be asked to sign a ***Request, Disclosure and Authorization of Medical Records Form***. Our practice will accommodate *reasonable* requests.

Other names for the ***Request, Disclosure and Authorization Form*** are: *Authorization for Use or Disclosure of Individually Identifiable Health Information; Patient Authorization for Disclosure to Designated Individually Identifiable Health Information Provider; Provider Request for Disclosure from another Covered Entity; Request for Access to Individually identifiable Health Information.*

### **Uses and Disclosures of Individually Identifiable Health Information Based Upon Your Written**

**Authorization:** Other uses and disclosures of your IIHI will be made only with your written authorization, unless otherwise permitted or 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 of disclosure indicated in the authorization. You will be asked to sign a ***Request, Disclosure and Authorization Form*** for disclosure of your IIHI.

You have the opportunity to agree or object to the use or disclosure of all or part of your IIHI. If you are not present or able to agree or object to the use or disclosure of the IIHI, then your physician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the Individually identifiable health information that is relevant to your health care will be disclosed.

### **Others Involved in Your Health Care:**

Unless you object, we may disclose to your spouse, a member of your family, a relative, a close friend, or anyone else you identify, your IIHI that directly relates to that person's involvement in your health care. For example, making appointments for you, making calls to the office on your behalf, or being present in the exam room with the physician. We may use or disclose IIHI to notify or assist in notifying a family member, personal representative, or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your IIHI to an authorized public or private entity to assist in disaster relief efforts and the coordinate uses and disclosures to family or other individuals involved in your health care.

You may list the person or persons whom you designate your authorization for North Central Texas Urology to communicate with, without additional forms to be completed. You may amend this list at anytime in writing by contacting the person listed at the end of this Notice. You may list the person or persons authorized to receive and disclose IIHI on your behalf on the ***Acknowledgment of Review of Notice of Privacy Practices***.

**Electronic Health Information Exchange:** North Central Texas Urology participates in a Health Information Exchange (HIE). An HIE allows participating providers secure, immediate electronic access to your protected health information as necessary for treatment. You have the option to "opt-out" of this participation.

**Emergencies:** We may use or disclose your IIHI in an emergency treatment situation. If this happens, your physician shall try to obtain your consent as soon as reasonably practical after the deliver of treatment. If your physician or another physician in the practice is required by law to treat you and the physician has attempted to obtain your consent but is unable to obtain your consent, he or she may still use or disclose your IIHI to treat you.

**Request Restrictions:** You may request that we restrict or limit how your Individually identifiable health information is used or disclosed for treatment, payment, or health care operations. We do NOT have to agree to this

restriction, but if we do agree, we will comply with your request except under emergency circumstances. You may request that we limit disclosure to family members, other relatives, or close personal friends who may or may not be involved in your care.

A ***Restriction of Personal Health Information Form*** can be furnished to you so that you can request whom you do not want your IIHI disclosed to. To request a restriction, submit the following in writing: (a) the information to be restricted, (b) what kind of restriction you are requesting (i.e., on the use of information, disclosure of information, or both), and (c) to whom (the name/s, parties, etc.) the restrictions apply. Please send the request to the address and person listed at the end of this document. Forms are also available for ***Acceptance/Denial of Requested Restriction*** and ***Termination of Patient Restriction***.

**Receiving Confidential Communications by Alternate or Electronic Means:** You may request that we send communications of Individually Identifiable Health Information by alternative or electronic means or to an alternative location. This request must be made in writing to the person listed below. We are required to accommodate only reasonable requests. Please specify in your correspondence exactly how you want us to communicate with you and, if you are directing us to send it to a particular place, the contact/address information.

**Inspection and Copies of Individually Identifiable Health Information:** You may inspect and/or copy health information that is within the designated records set, which is information that is used to make decisions about your care. Texas Law requires that requests for copies be made in writing, and we ask that your request for inspection of your health information also be made in writing. Please send your request to the person listed at the end of this document.

We may ask that a narrative of that information be provided rather than copies. However, if you do not agree to our request, we will provide copies.

We can refuse to provide some of the information you ask to inspect or ask to be copied for the following reasons:

- The information is psychotherapy notes.
- The information reveals the identity of a person who provided information under a promise of confidentiality.
- The information is subject to the Clinical Laboratory Improvements Amendments of 1988.
- The information has been compiled in anticipation of litigation.

We can refuse to provide access to or copies of some information for other reasons, provided that we arrange for a review of our decision upon your request. Any such review will be made by another licensed health care provider who was not involved in the prior decision to deny access.

Texas law requires us to be ready to provide copies within fifteen (15) days of your request. We will inform you when the records are ready or if we believe access should be limited. If we deny access, we will inform you in writing. Texas HB300, effective September 1, 2012, mandates physicians who use Electronic Health Records (EHR's) provide requested patient records in an electronic format within 15 business days of receiving a written request, unless there is an allowable exception.

HIPAA permits us to charge a reasonable cost-based fee. A fee of \$25 (or more, depending in the number of pages and copies) may be charged, depending on the size of your records.

**Amendment of Medical Information:** You may request an amendment of your medical information in the designated record set by filling out a ***Patient Request for Amendment of Individually Identifiable Health Information Form*** and have it sent to the person listed at the end of this document. We will respond within 60 days of your request. We may refuse to allow an amendment for the following reasons:

- The information wasn't created by this practice or the physicians in this practice.
- The information is not part of the designated record set.
- The information is not available for inspection because of an appropriate denial.
- The information is accurate and complete.

Even if we refuse to allow an amendment, you are permitted to include a patient statement about the information at issue in your medical record. If we refuse to allow an amendment, we will inform you in writing by completing an **Acceptance/Denial of Requested Amendment Form**.

If we approve the amendment, we will inform you in writing, allow the amendment to be made and tell others that we now have the correct information. The **Acceptance/Denial of Requested Amendment Form** will be used in these situations as well.

**Accounting of Certain Disclosures:** HIPAA privacy regulations permit you to request, and us to provide, an accounting of disclosures that are other than for treatment, payment, health care operations, or made via an authorization signed by you or your representative. A **Disclosure Accountability Request Form** is available for this purpose. Our office will have this information for the patient no later than sixty (60) business days from the date of the request. Your first accounting of disclosure (within a 12-month period) will be free. For additional requests within that period we are permitted to charge for the cost of providing the list. If there is a charge, we will notify you, and you may choose to withdraw or modify your request *before* any costs are incurred.

#### **APPOINTMENT REMINDERS, TREATMENT ALTERNATIVES, AND OTHER BENEFITS**

We may contact you by telephone, mail, or email to provide appointment reminders, information about treatment alternatives, or other health-related benefits and services that may be of interest to you.

#### **COMPLAINTS**

If you are concerned that your privacy rights have been violated, you may contact the person listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. A **Patient Privacy Complaint Form** is available for you for this purpose. We will not retaliate against you for filing a complaint with the government or us.

For more information about HIPAA, or to file a complaint with the Office of Civil Rights for complaints involving covered entities located in Arkansas, Louisiana, New Mexico, Oklahoma or Texas:

Region VI, Office of Civil Rights  
U. S. Department of Health and Human Services  
1301 Young Street, Suite 1169  
Dallas, TX 75202  
Voice Phone: (214)767-4056 Fax: (214)767-0432  
TDD: (214)767-8940

#### **OUR PROMISE TO YOU**

We are required by law and regulation to protect the privacy of your medical information, to provide you with this Notice of our Privacy Practices with respect to Individually Identifiable Health Information, and to abide by the terms of the Notice of Privacy Practices in effect.

#### **QUESTIONS AND CONTACT PERSON FOR REQUESTS**

If you have any questions or want to make a request pursuant to the rights described above, please contact:

Office Manager and Compliance Officer  
North Central Texas Urology  
831 E. Eureka Street  
Weatherford, TX 76086  
817-599-3690  
Website: [www.ncturology.com](http://www.ncturology.com)

A copy of this Notice of Privacy Practices is also available on our website at [www.ncturology.com](http://www.ncturology.com)

Updated 8/2013

**ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES  
AND REVIEW OF  
PATIENT RESTRICTION OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION**

I have received and reviewed North Central Texas Urology’s **Notice of Privacy Practices**, which explains how my Individually Identifiable Health Information (IIHI) may be used or disclosed. IIHI is the same as my medical information. I have also received a copy of this **Acknowledgment of Review and Patient Restriction of Protected Health Information**. I can fill in the names of friends, relatives, spouse, immediate family, etc. below if I want them to be able to have access to my IIHI.

I am confirming receipt of this Acknowledgment of Review of Privacy Practices and identifying who has access to my IIHI, other than myself. Please check below.

- I do not want anyone in my family to have access to my IIHI. I am the only one who should have access to my IIHI.
- It is agreed and acceptable for my “spouse only” to have access to my IIHI.
- It is agreed and acceptable for any of my immediate family members to have access to my IIHI.
- Patient is under eighteen (18) years of age and understands that his/her legal representative has access to his/her IIHI and the legal representative is signing below.
- I do not want anyone to have access to my IIHI other than the person/s listed below:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

- It is acceptable to leave a detailed, medical phone message for me at the following number:

(\_\_\_\_\_) \_\_\_\_\_  Home  Work  Cell

\_\_\_\_\_  
Printed Name of Patient

\_\_\_\_\_  
Signature of Patient **IF NOT A MINOR**

\_\_\_\_\_  
Signature of Personal/Legal Representative **IF PATIENT A MINOR**

\_\_\_\_\_  
Personal/Legal Representative’s Relationship to Patient

Date \_\_\_\_\_

Avi T. Deshmukh, M.D.

\_\_\_\_\_  
Signature of Compliance Officer for North Central Texas Urology

\_\_\_\_\_  
Date