Lubbock Urology Clinic, L.L.P.

HIPAA PROTECTED HEALTH INFORMATION DISCLOSURE

I understand that, under the Health Insurance Portability & Accountability Act of 1996, as amended and supplemented (HIPAA), I have certain rights to privacy regarding my protected health information (PHI). PHI may originate in your medical record at Lubbock Urology Clinic, LLP ("LUC") or may be received from outside health entities and filed in your medical record.

I understand that this information can and will be used by LUC to: (a) Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly, (b) Obtain payment from third-party payers, (c) Conduct normal healthcare operations such as quality assessments and physician certifications, (d) Notification of educational events specific to my medical condition through LUC or networking organizations, (e) Consent to property transfer of specimen (tissue obtained during a medical test) to LUC, and (f) Any such other purposes permitted under HIPAA.

I understand I can obtain access to my medical records through my patient portal. I understand my records can be sent to another healthcare provider with my written authorization free of charge and Lubbock Urology Clinic has 72 business hours to process and postmark my records requested.

I understand all third party requests (insurance companies, attorneys, etc.) for my medical records must be signed by me as an authorization to release records and they are responsible for the fee's to process and mail.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that LUC has the right to change its Notice of Privacy Practices from time to time and that I may obtain a current copy of the Notice of Privacy Practices from my healthcare provider's office.

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 health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions. I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

1. I consent to LUC employees identifying themselves and **leaving messages on my answering machine / voicemail** (if I have one) for the purpose of appointment confirmation, follow-up after procedure, or to inform me that I need to call you. ____Yes _____No
2. I consent to LUC employees identifying themselves and **leaving a message with those who answer my home phone** for the purpose of appointment confirmation, follow-up after procedure, or to inform me that I need to call you. _____Yes _____ No
3. I consent to LUC employees **contact me at work** (if applicable) for the purpose of appointment confirmation, follow-up after procedure, or to inform me that I need to call you. _____Yes _____No
4. I consent to LUC employees disclosing my private health information, such as test results and billing information with designated family member or personal representative. _____Yes _____No

*** **If you answered <u>YES</u> to the above question (#4), please list below the person(s) to whom such information may be disclosed.**

Name: _____Relationship:_____Phone:_____

Alternate: _____Relationship:_____Phone:_____

I acknowledge that I have received a copy of the Notice of Privacy Practices, and the above information is correct.

_____ _____

Signature of Patient or Personal Representative Date

_____ _____

Print Name of Patient or Personal Representative Relationship to Patient