North Coast Urology Medical Associates, Inc.
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## JOINT NOTICE OF PRIVACY PRACTICES

North Coast Urology Medical Associates, Inc. participates in an Organized Health Care Arrangement (OHCA) with the University of California, San Diego Health System (UCSD) for purposes of compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This notice is jointly used by and jointly describes the practices of all participants within the OHCA, including, without limitation any health care professional authorized to enter information into your medical record. UCSD also has its own Notice of Privacy Practices that can be accessed at http://health.ucsd.edu/hipaa/Pages/hipaa.aspx.

The OHCA will follow the terms of this joint notice. The OHCA may share medical information with each other for treatment, payment, or health care operations related to the OHCA as well as for research related purposes conducted at UCSD and at all related UC Medical Groups and UC Hospitals.

## HIPAA PRIVACY AUTHORIZATION FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

This authorization is prepared pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C. Section 1320d, et. seq., and regulations promulgated thereunder, as amended from time to time (collectively referred to as “HIPAA”).

This authorization affects your rights in the privacy of your personal health care information (PHI). Please read it carefully before signing. Your decision to sign this document will not affect your treatment or care plan. YOU MAY REFUSE TO SIGN THIS AUTHORIZATION.

By signing this authorization you agree that North Coast Urology Medical Associates, Inc. or its Business Associates may use your personal health care information to request treatment authorizations, accomplish treatment, obtain payment, or perform healthcare operations. Please be assured that we will not share your medical information with anybody not directly associated with your medical treatment without your permission, as directed by the HIPAA guidelines.

While North Coast Urology Medical Associates, Inc. has reserved the right to change the terms of its HIPAA Privacy Notice, copies of the Privacy Notice as amended are available from the North Coast Urology Medical Associates, Inc. office, or by sending a written request with return address to 3609 Vista Way, Oceanside, CA 92056.

In accordance with your rights under, and subject to certain restrictions imposed by HIPAA, you may inspect or copy your PHI in the designated record set maintained by North Coast Urology Medical Associates, Inc. for as long as the PHI is maintained in the designated record set. You have the right to revoke this authorization, in writing, at any time, except to the extent that North Coast Urology Medical Associates, Inc. has taken action in reliance on it.
A revocation is effective upon receipt by North Coast Urology Medical Associates, Inc. of a written request to revoke and a copy of the executed authorization form to be revoked at the address listed above.

This authorization shall expire upon the earlier occurrence of: (a) revocation of the authorization; (b) a finding by the Secretary of the U.S.Department of Health and Human Services Office of Civil Rights that this authorization is not in compliance with requirements of HIPAA; (c) complete satisfaction of the purposes for which this authorization was originally obtained, to be determined in the reasonable discretion of North Coast Urology Medical Associates, Inc., or (d) six years from the date this authorization was executed.

By signing this authorization you acknowledge and agree that any information used or disclosed pursuant to this authorization could be at risk for re-disclosure by the recipient and no longer protected under HIPAA.

North Coast Urology Medical Associates, Inc. will provide patient with a copy of this signed authorization upon request.

If applicable please list names and contact information of persons whom we have your permission to share your health information:

Name: ___________________________Relationship: ____________________ Phone #: (_____) ____________

Name: __________________________ Relationship: ____________________ Phone #: (_____) ____________

Acknowledged and agreed to by:

Patient Signature: _____________________________________________________ Date: ____/____/______

Print Name: ____________________________________________________

Or, on BEHALF OF PATIENT:

Signature: ___________________________________________________________ Date: ____/____/______

Print Name: _________________________________________________________

Relationship to Patient: ______________________________