NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION AND TO PROVIDE YOU WITH A NOTICE OF ITS LEGAL DUTIES AND PRIVACY PRACTICES. THIS NOTICE APPLIES TO ALL OF THE MEDICAL RECORDS GENERATED BY FAMILY PRACTICE BY THE LAKE, AS WELL AS ANY RECORDS WE RECEIVE FROM OTHER PROVIDERS.

USES AND DISCLOSURES REQUIRING YOUR CONSENT: WITH YOUR CONSENT, FAMILY PRACTICE BY THE LAKE MAY USE AND DISCLOSE YOUR HALTH INFORMATION FOR THE FOLLOWING PURPOSES:

TREATMENT: FAMILY PRACTICE BY THE LAKE MAY USE YOUR HEALTH INFORMATION IN THE PROVISION AND COORDINATION OF YOUR HEALTHCARE. WE MAY DISCLOSE ALL OR ANY PORTION OF YOUR MEDICAL RECORD INFORMATION TO YOUR ATTENDING PHYSICIAN, CONSULTING PHYSICIAN(S), NURSES, TECHNICIANS, MEDICAL STUDENTS, AND OTHER HEALTHCARE PROFESSIONALS. DIFFERENT DEPARTMENTS MAY SHARE HEALTHCARE INFORMATION ABOUT YOU IN ORDER TO COORDINATE SPECIFIC SERVICES, SUCH AS PRESCRIPTIONS, LAB WORK, X-RAYS, ETC.

PAYMENT: FAMILY PRACTICE BY THE LAKE MAY RELEASE YOUR HEALTH INFORMATION ABOUT YOU FOR THE PURPOSE OF DETERMINING COVERAGE, BILLING, CLAIMS MANAGEMENT, MEDICAL DATA PROCESSING, AND REIMBURSEMENT. THE INFORMATION MAY BE RELESED TO AN INSURANCE COMPANY, THIRD PARTY PAYOR OR OTHER ENTITIY (OR THEIR AUTHORIZED REPRESENTATIVES) INVOLVED IN THE PAYMENT OF YOUR MEDICAL BILLS AND MAY INCLUDE COPIES OR EXCERPTS OF YOUR MEDICAL RECORDS WHICH ARE NECESSARY FOR PAYMENT OF YOUR ACCOUNT.

USES AND DISCLOSURES REQUIRING YOUR AUTHORIZATION: FAMILY PRACTICE BY THE LAKE MAY NOT DISCLOSE YOUR HEALTH INFORMATION TO PERSONS OUTSIDE OF FAMILY PRACTICE BY THE LAKE FOR PURPOSES OTHER THAN TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS WITHOUT YOUR AUTHORIZATION. YOU HAVE THE RIGHT TO REVOKE ANY AUTHORIZATION YOU HAVE PREVIOUSLY GIVEN BY SUBMITTING A WRITTEN STATEMENT OF REVOCATION TO FAMILY PRACTICE BY THE LAKE.

AS OTHERWISE REQUIRED BY LAW: FAMILY PRACTICE BY THE LAKE WILL NOT DISCLOSE YOUR HEALTH INFORMATION IN ANY SITUATION IN WHICH SUCH DISCLOSURE IS REQUIRED BY LAW (I.E. CHILD ABUSE, DOMESTIC ABUSE, ETC).

BY SIGNING THIS DOCUMENT, YOU ARE NOT IDENTIFYING YOUR AGREEMENT WITH THE PRIVACY PRACTICES OF FAMILY PRACTICE BY THE LAKE, BUT YOU ARE RECOGNIZING THAT YOU HAVE RECEIVED AND ACKNOWLEDGED THEM. YOU ARE ALSO ACKNOWLEDGING THAT YOU HAVE NBEEN MADE AWARE OF YOUR HEALTH INFORMATION RIGHTS UNDER IDAHO STATE HIPAA LAWS.

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SIGNATURE **DATE**

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NAME (PLEASE PRINT) **RELATION TO PATIENT**