Teton Medical Group Privacy Notice and Consent

Patient Name _____

IMPORTANT NOTICE REGARDING THE PRIVACY OF YOUR HEALTH INFORMATION

Effective March 26, 2013 revised federal regulations restrict the use and disclosure of your private health information (PHI) by our practice and other organizations. It has been, and continues to be the policy of our practice to protect the privacy of our patient's health information and to comply with any regulations regarding the use and disclosure of patient information. The following summarize the new law and under what circumstances it may be disclosed.

Permitted Disclosures

Our practice is permitted to use and disclose your PHI for treatment and healthcare operation purposes. These uses include sharing your PHI with other healthcare providers for confirmation of a diagnosis, using your PHI to accurately bill services we provide to you, providing your PHI to your insurance company for reimbursement, to remind you of appointments, and as part of our quality improvement program.

We are also permitted to disclose your PHI in compliance with guidelines outlined by law and when required to do so by various government agencies. We may also disclose your PHI to family members, relatives, or close personal friends when the information we disclose is relevant to the individuals' involvement with your care or is required to assist in your healthcare (e.g. pick up prescriptions or other documents, notes or instructions etc.) with your consent. We will disclose your PHI when we refer you to other physicians or providers of healthcare as part of your treatment. Finally, we reserve the right to change a privacy practice described in this notice as may be permitted or required by law and to make such change effective for all protected health information.

Restricted Disclosures

You have the right to request restrictions on certain uses and disclosures of your PHI and to request portions of the PHI be amended. However, our practice is not obligated to agree to request restrictions or to amend your PHI in the manner you request. You also have the right to inspect and receive an accounting of disclosures of your health information.

Authorization

Our practice will make other uses and disclosures of your PHI **ONLY** after obtaining your written authorization. If you authorize a use not contained in this notice, you may revoke your authorization at anytime by notifying us in writing that you want to revoke your authorization.

I authorize the following people to have access to my medical records:

Name: _____ Relation: _____

Name: _____ Relation: _____

Concerns

If you believe your privacy rights have been violated, you may make a complaint by contacting our privacy officer at 255 N 3rd E, Rexburg, ID 83440, or by telephone at (208) 356-7585. You may also contact the Secretary of the Department of Health and Human Services. No individual will be retaliated against for filing a complaint. If you have questions or complaints about services provided by Madisonhealth in our office, contact them at (208) 359-6539.

Acknowledgment

I acknowledge that I have received this summary and copy of the notice of practices regarding the disclosure of my PHI. I agree that a photocopy of this agreement shall be valid as the original.

Patient/Guardian
Signature: _____ Date: _____

PLEASE REVIEW BOTH SIDES OF FORM