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BOISE, IDAHO 83704
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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW NOTICE CAREFULLY.

We are required by law to maintain the privacy of your protected health information, to notify you of our legal duties and privacy practices with respect to your health information and to notify affected individuals following a breach of unsecured health information.

1. Uses and disclosure we may make without written authorization. We may use or disclose your health information for certain purposes without your written authorization, including the following :

Treatment. We may use or disclose your information for purposes of treating you. For example, we may provide, coordinate or manage healthcare and related services by one or more providers.

Payment. We may use and disclose your information in order to obtain payment for services provided to you. For example, we may disclose information to your health insurer to confirm coverage, obtain pre-authorization or payment for treatment.

Health Care Operations. We may use and disclose your information to operate your business. For example, we may use information to ensure quality customer service.

Release of Information to Family/Friends. Unless clearly instructed to the contrary.

Other Uses or Disclosures. We may use or disclose your information for certain other purposes allowed by 45 CFR 164.512.

2. **Uses and Disclosures With Your Written Authorization.** Other uses and disclosures not described in this Notice will be made only with your written authorization, including most uses or disclosures of psychotherapy notes; for most marketing purposes; or if we seek to sell your information. You may revoke your authorization by submitting a written notice to the Privacy Contact identified below. The revocation will not be effective to the extent we have already taken action in reliance on the authorization.

3. **Your Rights Concerning Your Protected Health Information.** You have the following rights concerning your health information. To exercise any of these rights, you must submit a written request to the Privacy Officer identified below.

- You may request additional restrictions on the use or disclosure of information for treatment, payment or healthcare operations. We are *not* required to agree to the requested restriction except in the limited situation in which you or someone on your behalf pays for an item or service, and you request that information concerning such item or service not be disclosed to a health insurer.
- We normally contact you by telephone or mail at your home address. You may request that we contact you by alternative means or at alternative locations or accounts. We will accommodate reasonable requests.
- You may inspect and obtain a copy of records that are used to make decisions about your care or payment for your care, including an electronic copy. We may charge you a reasonable cost-based fee for providing the records. We may deny your request under limited circumstances, e.g., if we determine that disclosure may result in harm to you or others.
- You may request that your protected health information be amended. We may deny your request for certain reasons, e.g., if we did not create the record or if we determine that the record is accurate and complete.
- You may obtain a paper copy of this Notice upon request.

4. **Changes To This Notice.** We reserve the right to change the terms of this Notice at anytime and to make the new Notice effective for all protected health information that we maintain. If we materially change our privacy practices, we will post a copy of the current Notice in our reception area. You may obtain a copy of the Notice from our receptionist or Privacy Officer.

5. **Complaints.** You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint with us by notifying our Privacy Officer, Miren Arozamena. All complaints must be in writing. We will not retaliate against you for filing a complaint.

Patient or Representative Signature

Date

Printed Patient Name

Date of Birth

Relationship to Patient (if other than patient): _____