FOOTHILLS FAMILY MEDICINE
Your Natural Path to Health

Diana R. Crumrine ND
1416 W Washington St
Boise, ID 83702
www.myfoothillsfamilymed.com

Your Health Information Privacy Rights

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain privacy rights concerning your health care information. Under this law your health care provider generally cannot give your information to your employer, use or share your information for marketing or advertising purposes, or share private notes about your mental health counseling sessions without your written consent. As one of your health care providers it is our responsibility to keep your information safe and secure. We also need to make sure that your information is protected in a way that does not interfere with your health care. It is important that you understand that your information can be used and shared in the following ways:

- For your treatment and care coordination. Multiple health care providers may be involved in your treatment directly and indirectly.
- With your family, friends, relatives or others that you identify who are involved in your health care or health care bills.
- To protect public health, such as reporting when the flu is in your area.
- Threats to health or safety that involves you harming yourself or others.
- To make required reports to the police, such as gunshot wounds.
- Information about employees can be disclosed to employers regarding worker's compensation.
- Obtain payment from third party payers

In order to provide you with service that best meets your privacy needs, please tell us how best to contact you when needed. Please check all that apply:

_____ Please do not phone me at home. Use this alternate phone number:_____
_____ Please do not phone me at work. Use this alternate phone number:_____
_____ Please do not leave messages on my answering machine
_____ Please do not contact me by email.
_____ Please send mail, including my bills to this alternate address:_____
_____
_____ Other request (please describe):_____

_____	_____	_____
Printed Name of Patient	Signature of Patient	Date
_____	_____	_____
Printed Name of Parent/Guardian	Signature of Parent/Guardian	Date
_____	_____	_____
Printed Name of Provider	Signature of Provider	Date

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E-mail Authorization and Consent Agreement

I have been advised that:

- E-mail is never, ever appropriate for urgent or emergency problems
- E-mail is not confidential. Employers have a legal right to monitor e-mail if they choose; system operators for most e-mail systems have access to all e-mail that passes through their systems.
- E-mail communications travel across the public Internet. It is not always possible to verify that e-mail is actually received, opened and read by the addressee.
- There is not a way to assure the privacy of e-mail on a shared computer or e-mail account.
- All e-mail correspondence will become a part of my medical record at Foothills Family Medicine. It is extremely important to include my name on each and every e-mail sent to Foothills Family Medicine.
- Since e-mail may not be monitored while my clinician is away on business or on vacation, I will follow up by telephone or in person if I do not receive a response within one week.

I have been provided with information about the use of Internet e-mail to communicate matters pertaining to my health and health care and I understand that issues and concerns inherent in this use. I have been provided with information about the use of Internet e-mail communications between my health provider, including information concerning my heath care and personal medical information. I understand that I may revoke this agreement at any time by contacting my clinician.

I designate that all e-mail correspondence coming from me or to me should be sent to the following:

Internet e-mail address:_____

Printed Name of Patient	Signature of Patient	Date
Printed Name of Parent/Guardian	Signature of Parent/Guardian	Date
Printed Name of Provider	Signature of Provider	Date