IMPORTANT NOTICE REGARDING THE PRIVACY OF YOUR HEALTH INFORMATION

Robert L. Coray M.D.

Effective April 14, 2003 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 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, payment and health care operation purposes. These uses include sharing your PHI with other health care providers for confirmation of a diagnosis, using your PHI to accurately bill services we provided to you, providing your PHI to 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 wen 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 individual involvement with your care or is required to assist in your health care (e.g. pick up prescriptions or other documents, noted for follow up care, and instructions. etc.) We will disclose your PHI when we refer you to other physicians and provider of health care. 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 changed 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 requests restrictions or to amend your PHI in the manner you request. You also have the right to inspect and receive a copy of your PHI, but may pay a reasonable charge for labor and costs associated with coping your PHI. Finally, you have the right to receive an accounting of disclosures of your health information.

Authorization

Our practice will make other uses and disclosures of your protected health information ONLY after obtaining your written authorization. If you authorize a use not contained in this notice, you may revoke your authorization at any time 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 office administration, 393 E 2nd N, Rexburg, Id 83440 or by phone at (208) 356-9086. You may also contact the secretary of the department of health and human services. No individual will be retaliated against for filling a complaint.

HIPPA Acknowledgement

I acknowledge that I have read this summary of the notice of practices regarding the disclosure of my private health information.

Patient/Guardian

Please Print:_____Date:_____

FINANCIAL AGREEMENT

I hereby give lifetime authorization for payment of insurance benefits to be made directly to ROBERT L. CORAY MD, and any assisting physicians for services rendered. And that I am responsible for any unpaid portion after my insurance has processed the claim. I understand payment is due at the time of service for private pay, co-ins, co-pay, or deductible if applicable. And that I may receive a separate bill for Labs or radiology or other entity. I agree and understand that if payment is not made *in full within 60 days* of service a **21% interest** charge will be applied to my account every month their after. I authorize treatment of the above listed patient by a provider at ROBERT L. CORAY MD. I agree that a photocopy of this agreement shall be valid as the original.

Patient/Guardian Signature _____ Date:_____