PARTNERS IN HEALTH
FAMILY MEDICINE

HIPAA Notification and Consent for Use and Disclosure of Protected Health Information

Essentially this notice describes how medical information about you may be used and disclosed and how you can get access to this information.

This practice is a member of the Integrated Physician Network or iPN. This means that your health information is available to all members of the network in order to provide for continuity of care and promote meaningful use of your healthcare information. A pamphlet outlining the iPN network and how your healthcare information is handled in their Enterprise Chart system is available on request.

This practice also endorses, supports, and participates in electronic Health Information Exchange (HIE) as a means to improve the quality of your health and healthcare experience. The HIE in Colorado is known as CORHIO. HIE provides us with a way to securely and efficiently share patients' clinical information electronically with other physicians and health care providers that participate in the HIE network. Using HIE helps your health care providers to more efficiently share information and provide you with better care. The HIE also enables emergency medical personnel and other providers who are treating you to have immediate access to your medical data that may be critical for your care. Making your health information available to your health care providers through the HIE can also help reduce your costs by eliminating unnecessary duplication of tests and procedure. However, you may choose to opt-out of participation in CORHIO, or cancel an opt-out choice, at any time.

On occasion, we may also contact you on your cell phone and/or email to receive your feedback on your visit. We will never send you any spam. You may also opt out of this participation at any time.

This office is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and healthcare operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination, and test results, diagnosis, treatment and applying for future care or treatment. It also includes billing documents for those services.

In practical terms, I understand the following:

- That Partners in Health Family Medicine with my consent may call my home or other designated location and leave a message on voicemail or in person in reference to any items that may assist in treatment, payment and healthcare operations.
- That Partner in Health Family Medicine with my consent may mail or email my home or other designated location any items or information that may assist in treatment, payment, and healthcare operations.
- That I have the right to restrict or limit how Partners in Health Family Medicine discloses my personal health information if given written notice. I also understand that Partners in Health Family Medicine is not required to agree to this request.
- That there will be incidental uses or exposures of my name such as a sign in sheet.
- That situation may arise such that Partners in Health Family Medicine may need to inform a family member, relative or close personal friend of your protected health information.

In summary, Partners in Health Family Medicine will do everything it can to protect your health information.
If you would like more information about our privacy practices, please contact the office in writing.

By signing this document, I understand the above statements regarding my protected health information and Partners in Health Family Medicine's ability to carry out treatment, payment, and healthcare operations on my behalf.

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Signature of Patient or Legal Guardian

Printed Name of Patient	*Patient's Date of Birth*	*Date*