Insight and Empowerment, LLC
1908 Jennie Lee Drive, Idaho Falls, ID 83404
(208) 932-7048 phone
(208) 970-6188 fax
IE@insightandempowerment.com

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 IT CAREFULLY

Effective July 1, 2024, Idaho healthcare providers must obtain parental consent to treat unemancipated minors or face civil liability except in emergency cases. In addition, parents will have the right to access the medical records of their minor children subject to very limited exceptions; as well as subject to HIPPA laws.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operation (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. These duties and rights are set forth more fully in 45 C.F.R. part 164. We are required by law to abide by the terms of our Notice that is currently in effect.

Uses and disclosure of Protected Health Information: Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you or may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of students, licensing and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our

office. We may also call you by name in the waiting room when your clinician is ready to see you. We may disclose your protected health information, as necessary to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situation without your authorization. These situation include: as By Law, Public Health issues are required by law, Communicable situation include: as Required Abuse Or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors and Organ Donation: Research: Criminal Activity: Military Activity and Nation Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we much make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500

Other permitted and Required Uses and Disclosures will be made only with your consent, authorization or Opportunity to object unless required by law.

You may revoke this authorization at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: The following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. However, under Federal Law, you may not inspect or copy the following record: psychotherapy notes: information complied in reasonable anticipation of, or use in, a civil, criminal, or administrative action/proceeding. You may not inspect your protected health information that is subject to law that prohibits access to protected health information. You may request a copy of your medical record by appearing at the office in person or calling our office at (208) 932-7048. With a signed consent for us to disclose your medical records, electronic transmissions of your medical record may be sent to another provider at no cost.

You have the right to request a restriction of your protect health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information may not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your provider is not required to agree to a restriction that you may request. In the event the provider believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another healthcare professional. Records will be sent to your new provider at no cost, once a signed consent to disclose records is received.

You have the right to request to receive confidential communications from us by alternative means. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.

You may have the right to have your provider amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy officer of your complaint. We will not retaliate against your for filing a complaint.

- U.S. Department of Health and Human Services
  200 Independence Avenue, S.W.
  Room 509F HHH Bldg.
  Washington, D.C. 20201

- Email to OCRComplaint@hhs.gov

  Filing a Complaint | HHS.gov

This notice was published and becomes effective on/or before February 1, 2022. You have the right to discuss the contents of this notice. If you have any questions or objections about this Notice, or if you want to object to or complain about any use or disclosure or exercise any right as explained above, please contact our Privacy Contact:

Privacy Officer: Sarah Hernandez, LCSW, Owner/Clinical Supervisor
Phone: (208) 932-7048
Address: 1908 Jennie Lee Dr., Idaho Falls, ID 83404
E-mail: sarah@insightandempowerment.com

You can also reach her via email at IE@Insightandempowerment.com. We are required by law to maintain the privacy of and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. Signature below is only an acknowledgment you have received this notice.

Responsible Party Signature: _____Date: _____

Responsible Party Signature: _____Date: _____