HIPAA Notice of Privacy Practices

Congress passed the Health Insurance Portability and Accountability Act, or HIPAA, in 1996. Its primary purpose is to ensure that people who change jobs cannot be denied health insurance in a new job because of a pre-existing health condition. The law also established minimum standards of privacy and security to ensure that sensitive information about individuals' health would remain confidential.

HIPAA restricts the way "covered entities" can share personal health information. The law defines covered entities as any health plan, health care clearinghouse, or health care provider that transmits health-related data electronically. The Montana Department of Public Health and Human Services (DPHHS) is a covered entity under HIPAA, so we must take extra precautions to protect the personal health information of our clients.

What is Protected Health Information (PHI)?

HIPAA introduces a number of new concepts, the most important of which is PHI, or Protected Health Information. PHI is any information that relates to a person's medical condition or payment for health care that identifies or might identify that person.

In order to protect client privacy, HIPAA requires covered entities, including the department, to limit the amount of PHI that they request from clients or provide to others. In most cases, the department must get written authorization from clients before it can disclose their PHI. The department does not need authorization if the information:

- Is necessary to provide appropriate medical treatment;
- Was requested by the individual about himself/herself;
- Is required to be reported to an entity by law;
- Is required to be provided to comply with federal or state program mandates; or
- Is required to pay medical claims.

Patient or Legal Guardian: _____
(signature - legal guardian's must sign for minors)

Patient or Legal Guardian: _____
(printed name)

Relationship: _____ **Date: _____**

Please list the individuals and their information that you give permission for us to speak with regarding your treatment and/or account. This includes, but is not limited to, your spouse, the mother or father of a child, significant other of the patient, attorney, etc.

Please note that if the appropriate boxes are not checked for each individual listed below, we legally cannot speak with said individuals regarding your appointments and/or account. Thank you for your understanding.

EMERGENCY CONTACT:

Full Name:_____ DOB:_____

Relation to Patient: _____ Phone #: _____

☐ Okay to release information pertaining to my treatments/records (including any appointments you may have).

☐ Okay to release information pertaining to my account regarding all billing inquiries.

Full Name:_____ DOB:_____

Relationship to Patient:_____ Phone #:_____

☐ Okay to release information pertaining to my treatments/records (including any appointments you may have).

☐ Okay to release information pertaining to my account regarding all billing inquiries.

Full Name:_____ DOB:_____

Relationship to Patient:_____ Phone #:_____

☐ Okay to release information pertaining to my treatments/records (including any appointments you may have).

☐ Okay to release information pertaining to my account regarding all billing inquiries.

Full Name:_____ DOB:_____

Relationship to Patient:_____ Phone #:_____

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Full Name:_____ DOB:_____

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