

## **BOISE ENT PRIVACY NOTICE – USE AND DISCLOSURE OF HEALTH CARE INFORMATION CONSENT**

I understand that Boise ENT may collaborate with or be contacted by other health care providers to coordinate, manage, and provide health care to me as the patient. I hereby consent to Boise ENT sharing my health information and records electronically or through any other means necessary for the purposes of treatment, payment, or operations, including improving the overall quality of health care services provided to me and other patients (e.g., avoiding unnecessary or duplicate testing, etc.).

I consent to the inclusion in my electronic health records ("EHR") of sensitive diagnoses and related information such as HIV/AIDS, sexually transmitted diseases, genetic information, mental health, and substance abuse, etc. The EHR will be accessible by Boise ENT credentialed Providers as well as other individuals approved to access the EHR or obtain EHR information via data exchanges with the EHR for purposes related to treatment, payment, health care operations, and/or other purposes permitted by the Health Insurance Portability and Accountability Act (as amended, supplemented, or otherwise modified from time to time, "HIPAA").

As required by HIPAA, Boise ENT has implemented administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality and integrity of my information while under the control of Boise ENT.

I agree that Boise ENT may use and disclose my health information for a range of purposes, such as treatment, eligibility verification, and/or payment to healthcare providers, regulators, Third-Party Payors or their agents, including insurance companies, managed care organizations, state and federal government programs, Workers' Compensation programs, obtaining pre-admission or continued length of stay certification, quality of care assessment and improvement activities, evaluating the performance and qualifications of Providers, conducting medical and nursing training and education programs, conducting or arranging for medical review, audit services, ensuring compliance with legal, regulatory, and accreditation requirements, and public health and health oversight services.

I consent to Boise ENT's request for my health information from Third Party Payors and other providers of care to me, receipt of and release of my health information to or from Third Party Payors, providers of care, and social service agencies, whether written, verbal, or electronic, for the uses described above.

I also consent to Boise ENT's participation in health information exchanges and other data exchanges for treatment, payment, and operations, including the sharing of my information electronically.

I understand the importance of these consents in the context of my health care, and I acknowledge that my consent is provided without the need for my signature