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(208) 529-9292

PLEASE REVIEW IT CAREFULLY

ADDENDUM TO NOTICEE OF USE AND DISCLOSURES*

THIS ADDENDUM PROVIDES SPECIFIC DIRECTIONS FOR USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

PATIENT NAME: _____

ADDITIONAL PHI DISCLOSURE

I hereby provide authorization for the following persons to receive my PHI. *If **PHI** is disclosed under your authorization to person(s)/entities that are not subject to federal or state privacy laws, it may be re-disclosed and no longer protected.* The purpose of this disclosure of my **PHI** is *"At my request"*. I authorize discloser of my **PHI** to the following person(s)/entities:

_____

_____

_____

_____

NON-DISCLOSURE

I DO NOT want the following types of my PHI disclosed. Additional I do not authorize disclosure of my PHI to the identified person(s)/entities:

Condition/Treatment/Test Result/Other:	Person(s)/Entity ***DO NOT*** disclose my PHI to:
_____	_____
_____	_____
_____	_____
_____	_____

FINANCIAL DISCLOSURE

I hereby provide authorization for the following persons/entities to receive and/or inquire about my **Financial obligations associated with the care I have received.**

_____

_____

I have read, understand, and agree to all the provisions of this Financial Policy which includes your agreement for payment at time of treatment unless other arrangements are made prior to service or treatment. I hereby authorize the use and discloser of my individually identifiable PHI as stated in the Notice of Use and Disclosures except as excluded by this the addendum.

_____	_____	_____
Patient Name	**Authorized Signature**	**Date**

If not signed by the patient, please indicate relationship:

____ Parent, guardian, or caregiver of a minor patient
____ Beneficiary or personal representative of a deceased patient
____ Guardian or conservator of an incompetent patient
____ Other: _____

This is an addendum to the NOTICE OF USE AND DISCLOSURES. All information on Notice of Use and Disclosures as well as the Financial Policy apply in association with this document.