Woman to Woman

Dr. Valerie A. Knudsen M.D.

2831 Fort Missoula Road Suite 306
Missoula, MT 59804

Last Name: **First:** **MI:** **Date of Birth:**

Home Address: **City:** **State:** **Zip Code:**

Mailing Address: **City:** **State:** **Zip Code:**

Social Security Number: **Best Phone # to Reach You:**

Home Phone #: **Mobile Phone #:**

Occupation: **Employer:** **Work Phone #:**

Preferred Pharmacy: **Pharmacy Phone Number:**

Primary Care Physician: **Phone Number:**

Who You Were Referred By: **Phone Number:**

Marital Status: **Spouse Name:** **Date of Birth:**

Social Security Number: **Best Phone # to Reach Them:**

Employer: **Work Phone:**

EMERGENCY CONTACT INFORMATION

Emergency Contact: **Relation:** **Phone Number:**

EC Address: **City:** **State:** **Zip Code:**

EC Home Phone: **Cell Phone:** **Work Phone:**

I authorize Dr. Valerie A. Knudsen, M.D. and her staff to release any of my medical information necessary to my insurance company or other physicians I may be seeing at any given time. I realize I am responsible for all charges regardless of my insurance status and I hereby authorize my insurance benefits to be paid to Dr. Valerie A. Knudsen, M.D.

Print Name: **Signature:** **Date:**

Print Parent/ Guardian Name: **Signature:** **Date:**
(if patient is under the age of 18)

HIPPA Notice of Privacy Practices

This notice was published and becomes effective on April 14th 2003

Women to Women, Dr. Valerie A. Knudsen, M.D.
2831 Fort Missoula Road, Suite 306
Missoula, MT 59804
406-327-4395

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.

Uses and disclosures 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 you care and treatment for the purpose of providing healthcare services to you, to pay your healthcare bills, to support the operation of the physician's practice and any other use requires by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your health care with a third party.

Payment: Your protected health information will be used, as needed, to obtain payment for your healthcare services.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors, Organ Donation, Research, Criminal Activity, Military Activity, National Security, Worker's Compensation, and Inmates.

Required Uses and Disclosures: Under the law we must 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 you physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights:

- **You have the right to inspect and copy your protected health information.** Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of or use in a civil, criminal or administrative action or proceeding and protected health information that is subject to law that prohibits access to protected health information.

- **You have the right to request a restriction of you r protected health information.** Your physician is not required to agree to a restriction that you may request. If your physician 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.

- **You have the right to request or receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of the notice from us.**

- **You may have the right to have your physician amend your protected health information.**

- **You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.**

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

Signature below is only acknowledgment that you have received and understand this Notice of our Privacy Practices:

Signature: _____ Print Name: _____ Date: _____