Surgeons of Northern Illinois
20 Tower Court, Suite A Gurnee IL 60031
(847) 244-3525

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT AND CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- *Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.*
- *Obtain payment from third-party payers.*
- *Conduct normal healthcare operations such as quality assessments and physician certifications.*

I have received, read and understand your ***Notice of Privacy Practices*** containing a more complete description of the uses and disclosures of my health information. I understand that Surgeons of Northern Illinois has the right to change its ***Notice of Privacy Practices*** from time to time and that I may contact this office at any time at the address above to obtain a current copy of the ***Notice of Privacy Practices.***

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____ Relationship to Patient: _____

Signature: _____ Date: _____

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their Protected Health Information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I, _____, hereby request Surgeons of Northern Illinois to keep communication regarding my Protected Health Information confidential. To accomplish this request, please adhere to the following requests:

Communication Preference(s): ___Letter ___Cell ___Home ___Work

Phone: You can contact me by phone at _____ or _____
Leave messages on answering machine: ☐ Yes ☐ No

Can we send you e-mail reminders on appointments or account balances? ___Yes ___No
E-mail: You can contact me via e-mail @ _____

You may discuss my Protected Health Information with the following individuals:
Name _____Relationship_____ Phone #_____
Name _____Relationship_____ Phone #_____
Name _____Relationship_____ Phone #_____

Other requests for Confidential Communications: _____

Patient Signature: _____ Date: _____
If you are not the patient, please specify your relationship to the patient: _____