Northern Illinois Medical Associates

RECEIPT OF NOTICE OF PRIVACY PRACTICES FORM

I, _____, hereby give my consent to **Northern Illinois Medical Associates** to use or disclose, for the purpose of carrying out treatment, payment or healthcare operations, all information contained in the patient record of:

_____

Patient Name

I acknowledge receipt of the physicians' Notice of Privacy Practices. The notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential information.

I understand that the physician has reserved a right to change his privacy practices that are described in the Notice. I also understand that a copy of any revised Notice will be provided to me or made available at my request.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to the physician. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the physician's office.

The following person(s) can inquire, pick up records, prescriptions, take messages, and any other medical related issues related to my care.

1._____ Relationship: _____
2._____ Relationship: _____
3._____ Relationship: _____
4._____ Relationship: _____

Signed: _____ Date:_____

Relationship to the patient: _____