INTERNAL MEDICINE ASSOCIATES. S.C.
HIPAA CONSENT TO USE AND DISCLOSE PROTECTED HEALTH CARE INFORMATION

Our Notice of Privacy Practices:
The Notice of Privacy Practices for Internal Medicine Associates, S.C. (I.M.A.), which describes how I.M.A. may use and disclose our patients' Protected Health Care Information (PHI), is posted in our office and on our web site @www.internal medicine.org.

Right to Review the Notice of Privacy Practices:
I acknowledge that I.M.A. has provided me with access to their Notice of Privacy Practices, and I am aware that I have the right to obtain a printed copy and review the Notice before signing this consent.

Permission to Use and Disclose My Health Information:
By signing this form, I give I.M.A. permission to use and disclose my PHI to carry out treatment, payment and health care operations as detailed in their Notice of Privacy Practices.

Right to Refuse:
I understand that I have the right not to sign this consent. If I decline to sign this consent, I understand that I.M.A. will not provide me with treatment until I consent. However, treatment required by law such as emergency care will be provided whether or not I sign.

Changes to the Notice of Privacy Practices:
I acknowledge that I.M.A. may change their Notice of Privacy Practices as needed. I may obtain a current copy of any revisions by contacting their office at 847-462-5100.

Right to Request Restrictions on Use or Disclosure:
I understand that I have the right to submit a written request detailing how I want I.M.A. to restrict the use and disclosure of my PHI for the purpose of providing treatment, obtaining payment for services, and conducting health care operations. However, I understand that I.M.A. is not required to agree with my request, and that in all likelihood I.M.A. will not honor my request due to the number, complexity, and nature of the services they deliver. I.M.A. will notify me in writing of their decision to accept or decline any such restrictions.

Right to Withdraw Consent
I understand that I have the right to withdraw this consent at any time, but must do this in writing. All correspondence should be sent by certified mail to Internal Medicine Associates, S.C., 912 Northwest Highway – Suite 107, Fox River Grove, IL 60021. I understand that the withdrawal of my consent will not be effective for uses and disclosures that have already been made based upon my prior consent. If I withdraw this consent, then I.M.A., by law, will be unable to provide to me with further treatment or follow-up other than emergent care.

Effective Period:
This consent is valid unless and until I withdraw it in writing.

____
SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

______/______/______
DATE SIGNED