

NEUROLOGY SPECIALISTS OF NORTHERN ILLINOIS, SC

Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment and/or Healthcare Operations.

I understand that **Neurology Specialists of Northern Illinois** originates and maintains protected health information for the purposes of Treatment, Payment and Healthcare Operations as explained below:

▪**TREATMENT** includes activities performed by a health care provider, practitioner, office staff and other types of health care professionals providing care, coordinating or managing care with third parties and consultations with other health care providers. This consent also includes any practitioner who provides coverage for **Neurology Specialists of Northern Illinois** by telephone as the on-call practitioner.

▪**PAYMENT** includes activities involved in making a determination of eligibility for health plan coverage, billing and receiving payment for your health benefit claims, and utilization management activities that may include review of health Care services for medical necessity, justification of charges, pre-certification and pre-authorization.

▪**HEALTH CARE OPERATIONS** includes the necessary administrative and business functions of **Neurology Specialists of Northern Illinois**

I acknowledge receipt of **Neurology Specialists of Northern Illinois** Notice of Privacy Practices (NPP). I understand this document provides additional information about the use/disclosure of my protected health information. By initialing at the end of the paragraph, I acknowledge I have received a copy of **Neurology Specialists of Northern Illinois** notice. Initial here: _____

I understand that since **Neurology Specialists of Northern Illinois** has the right the change their Privacy Practice in accordance with the Law, the terms contained in the Notice may change as well. They will provide a copy of the most updated Notice in the reception area of the office. They are also required to provide me a copy of the notice on my first visit as required by Law. I will also be provided a copy of the notice upon request.

As more fully explained in the Notice, you have the right to request restrictions on how **Neurology Specialists of Northern Illinois** can use/disclose your protected health information for treatment, payment and/or health care operations. They are not required to agree with your request. If you request is approved, they are required to comply with your restriction unless the information is needed for emergency treatment. Restrictions should be noted on the form attached. These restrictions will stay in effect until otherwise terminated. Any other practitioner who provides coverage for **Neurology Specialists of Northern Illinois** is required to use/disclose your protected health information as stated in the Notice.

I understand that I have the right to revoke this consent provided that I do so in writing, except to the extent that **Neurology Specialists of Northern Illinois** has already used/disclosed the information relied upon by this consent.

Signature of Patient

Date

Name of Patient

FOR OFFICE USE ONLY

- Consent received by _____ on _____.
- Consent refused by patient and treatment refused as permitted.
- Consent added to the patient's medical record on _____.