Lincoln Park Family Physicians S.C.

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Lincoln Park Family Physicians, S.C. may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Lincoln Park Family Physicians' Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have a right to review the Notice of Privacy Practices prior to signing this consent. Lincoln Park Family Physicians S.C. reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Lincoln Park family Physicians' Privacy Officer at 1317 W. Diversey, Chicago, Illinois 60614.

With my consent, Lincoln Park Family Physicians S. C. may call my home or other designated location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, collection calls and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Lincoln Park Family Physicians, S.C. may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to Lincoln Park Family Physicians' use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Lincoln Park Family Physicians, S.C. may decline to provide treatment to me.

At my request, I authorize Lincoln Park Family Physicians, S.C. to disclose to:

_____ _____

Printed Name *Relationship*

The following Protected Health Information:

☐ Medical Information ☐ Billing Information ☐ Both

_____

Signature of Patient or Legal Guardian

_____ _____

Print Name of Patient or Legal Guardian Date

This authorization will continue until revoked by you (the patient) in writing