LAKE COUNTY MEDICAL GROUP, SC
NINA NEYMAN, M.D.
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INTERNAL MEDICINE

CONSENT FOR RELEASE AND USE OF CONFIDENTIAL INFORMATION AND RECEIPT OF NOTICE OF PRIVACY PRACTICES FORM

I, ______________________________ hereby give my consent to Lake County Medical Group to use or disclose, for the purpose of carrying out treatment, payment, or health care operations, all information contained in the patient record of

____.

I acknowledge receipt of the physician's Notice of Privacy Practices. The Notice of Privacy Practice 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 or her 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 upon 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 physicians. 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.

Signed______________________________________Date__________

If you are not the patient, please specify your relationship to the patient

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OVER ->

-Patient File

LAKE COUNTY MEDICAL GROUP
1170 E. BELVIDERE RD SUITE 202
GRAYSLAKE, IL 60030

LAKE COUNTY MEDICAL GROUP

REQUEST FOR CONFIDENTIAL COMMUNICATION

I, ______________________________ hereby request LAKE COUNTY MEDICAL GROUP to keep communications regarding my protected health information confidential. To accomplish this request, please adhere to the following requests.

Phone: You can contact me by phone at ______________________________
Leave messages on answering machine or voice mail _______Yes _______No
Leave message with any other person ______Yes ______No or only with:
____

Mail: Can be sent to my home address _______Yes _______No
Other Address: ______________________________

Fax: _______ Please do not contact me by FAX
_______ Please contact me by FAX at ______________________________

Billing: Billing information may be discussed with my spouse or the following persons ______________________________ and Lake County Medical Group or their billing agency _______Yes _______No

OTHER REQUESTS FOR CONFIDENTIAL COMMUNICATIONS:

____

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Signed: ______________________________________**Date:**______

If you are not the patient, please specify your relationship to the patient: ____________

LAKE COUNTY MEDICAL GROUP

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

HOW LAKE COUNTY MEDICAL GROUP MAY USE OR DISCLOSE YOUR HEALTH INFORMATION

Federal law requires Lake County Medical Group to maintain the privacy of individually identifiable health information and to provide you with notice of its legal duties and privacy practices with repeat to such information. Lake County Medical Group must abide by the terms and conditions of this Privacy Notice, as Lake County medical Group may revise this Privacy Notice from time to time.

A. USES OR DISCLOSURES OF HEALTH INFORMATION FOR TREATMENT, PAYMENT & HEALTH CARE OPERATIONS

When you sign a written consent, you agree that Lake County Medical Center may use your individually identifiable health information for treatment, payment, and health care operations. Examples of treatment, payment, and health care operations include:

* "Treatment" could include consulting with or referring your case to another health care provider. The type of health information that Lake County Medical Group could use or disclose includes, but is not limited to, such health conditions as blood type, diagnosis of your condition or pregnancy status.

* "Payment" could include Lake County Medical Group's efforts to obtain reimbursement from you or a responsible third party for services that Lake County Medical Group has provided to you.

* "Health care operations" could include activities such as quality assessment and improvement activities and audits of the process of billing you or a third party for health care services Lake County Medical Group provides to you. As part of Lake County Medical Group's treatment of you and operation of a health care organization, Lake County Medical Center may contact you, by phone or by mail, to provide appointment reminders or to provide information about treatment alternatives or other health-related services that may be of interest to you.

B.. RIGHT TO REVOKE

I acknowledge that I have the right to revoke this authorization by contacting the Chief Privacy Officer of Lake County Medical Group at (847)566-0300.

Patient's initials: ____________________

C. Signature

By signing below I acknowledge and affirm the statements in this authorization form.

____

Signature of patient or patient's representative

____

Printed name of patient or patient's representative

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Representative's relationship to patient

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