West Suburban Women's Health, Ltd.

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HIPAA FORM

Patient Name (*please print*):_____Date of Birth:_____

Parent Name (*if patient is under 18*): _____

*** BILLING RECIPIENT** (billing statement addressee**) :** □ **PATIENT** □ **PRIMARY INSURED** (please check one)

- **Home telephone**_____
  - □ Ok to leave message with detailed information
  - □ Leave message with call-back information only
- **Work telephone**_____
  - □ Ok to leave message with detailed information
  - □ Leave message with call-back information only
- **Cell Phone**_____
  - □ Ok to leave message with detailed information
  - □ Leave message with call-back information only

- **Written Communication**
  - □ Ok to mail to my home address
- **Authorization**

I authorize the individual listed below to have access to my medical records and discuss my personal information with the physician and the office staff.

_____
(Name of person) (Relationship)

_____
(Patient Signature) (Date)

Please note: Patients over the age of 18 are considered to be legal adults. Their visits and conversations with their physician are considered confidential. If your child is over 18, she must indicate in writing below if she wishes to grant access to her Private Health Information (PHI) to any member of her family.

I hereby give my consent to ***West Suburban Women's Health, Ltd*** to use or disclose, for the purpose of carrying out treatment, payment, or health care operations, all information contained in my patient record.

I acknowledge that the physician's Notice of Privacy Practices is available to me. It is offered at both the front desk upon request and also posted on the practice website *wswomenshealth.com*. 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 on the practice website wswomenshealth.com.

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.

Patient Signature:_____Date:_____

Reconfirm and Initial Annually: _____