HIPAA & Privacy of Protected Information

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize the listed providers to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment) -Obtaining payment from third party payers (e.g. my insurance company)
- The day-to-day healthcare operations of the office.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that the providers are not required to agree to these requested restrictions. I understand my private, identifying health information will be excluded from any educational or scientific use. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected. Automated scribe tools may be used during my visit. Exam and Consultation I understand that an examination does not bind me into any treatment agreement. I understand that I can request a copy of this form at any time.

Chicago Craniofacial Pain & Rehabilitation

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