ACKNOWLEDGE RECEIPT OF NOTICE OF PRIVACY

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

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!

The office is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination, and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Examples of Uses of Your Health Information for Treatment Purposes are:
• A nurse obtains treatment information about you and records it in a health record.
• During the course of your treatment, the physician determines he/she will need to consult with another specialist in the area. He/she will share the information with such specialist and obtain his/her input.

Example of Use of Your Health Information for Payment Purposes:
We submit requests for payment to your health insurance company. The health insurance company (or other business associate helping us obtain payment) requests information from us regarding medical care given. We will provide information to them about you and the care given.

Example of Use of Your Information for Health Care Operations:
We obtain services from our insurers or other business associates such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guideline development, training programs, credentialing, medical review, legal services, and insurance. We will share information about you with such insurers or other business associates as necessary to obtain these services.

Your Health Information Rights
The health and billing records we maintain are the physical property of the office. The information in it, however, belongs to you. You have a right to:

• Request a restriction on certain uses and disclosures of your health information by delivering the request to our office -- we are not required to grant the request, but we will comply with any request granted;
• Obtain a paper copy of the current Notice of Privacy Practices for Protected Health Information ("Notice") by making a request at our office;
• Request that you be allowed to inspect and copy your health record and billing record – you may exercise this right by delivering the request to our office;
• Appeal a denial of access to your protected health information, except in certain circumstances;
• Request that your health care record be amended to correct incomplete or incorrect information by delivering a request to our office/hospital. We may deny your request if you ask us to amend information that:
• Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
• Is not part of the health information kept by or for the office/hospital;
• Is not part of the information that you would be permitted to inspect and copy; or,
• Is accurate and complete.
If your request is denied, you will be informed of the reason for the denial and will have an

opportunity to submit a statement of disagreement to be maintained with your records;
• Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office/hospital;
• Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a request to our office/hospital. An accounting will not include uses and disclosures of information for treatment, payment, or operations; disclosures or uses made to you or made at your request; uses or disclosures made pursuant to an authorization signed by you; uses or disclosures made in a facility directory or to family members or friends relevant to that person's involvement in your care or in payment for such care; or, uses or disclosures to notify family or others responsible for your care of your location, condition, or your death.
• Revoke authorizations that you made previously to use or disclose information by delivering a written revocation to our office/hospital, except to the extent information or action has already been taken.

If you want to exercise any of the above rights, please contact EMILY COHEN LCSW, 773-655-9404, in person or in writing, during regular, business hours. [S]he will inform you of the steps that need to be taken to exercise your rights.

Signature: _____ Date: ___/___/_____.

Print Name: _____.

Witness: _____.

My signature of this form acknowledges that I have received a copy of the Emily Cohen's Notice of Privacy Practices. I understand that this document provides an explanation of the ways in which my health information may be used or disclosed by Emily Cohen and of my rights with respect to my health information. I have been provided with the opportunity to discuss any concerns I may have regarding the privacy of my health information.

Limits of confidentiality include any immediate threats of harm towards someone else or yourself. As a mandated reporter, I would have to inform on any disclosure of abuse or neglect towards another. Will make every effort to inform you before reporting. Please ask me if you have any questions about this limit of confidentiality