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Patient Name: ____________________________________ **Date of Birth:** _________/_________/____________

In accordance with Federal HIPPA (Health Insurance Portability and Accountability Act) Law, Central Medical Clinic is Providing you our confidentiality policy:

~ medical information belongs to the patient and/or his/her legal guardian
~ the clinic policy is to release information only to the patient, his/her legal guardian, his/her insurance Company and as required by law i.e. Worker's Compensation Act of Illinois
~ for release of information to others –not mentioned above- written consent is needed
~ medical record is property of the clinic and is maintained for the benefit of the patient, the medical staff, and the clinic. It is the clinics responsibility to safeguard both the records and it's informational content against loss, tampering and from use by unauthorized individuals
~ copies of medical records may be released to the patient and/or his/her legal representative only with Proper written authorization from the patient and/or his/her legal representative and with proper Identification
~ all policies concerning release of medical records is confidential and shall apply to the clinic's Employees, unless performing in their official capacity
~ employees are by policy required not to release patient information in any way without patients written Consent
~ the clinic's legal counsel may review medical record information without consent of the patient when The information is to be used in the defense of the clinic
~ the clinic's physicians may request and receive medical records of any patient they are treating
~ other physicians and other health care providers may request and receive copies of medical records With proper authorization from the patient and/or his/her representative
~ attorneys may request and receive medical records only with proper authorization from the patient
~ a subpoena properly served is required before medical records can be taken to court

I understand that I have the right to request restrictions as to how this information is used or disclosed for treatments, payments, or healthcare operations and that the clinic is not required to agree to the restrictions.
I have the right to revoke this consent in writing, except where the practice has already made disclosures in reliance on prior consent.
Central Medical Clinic of Chicago has the right to change the privacy policies without notice.
I also authorize the clinic to obtain e-Med Hx information regarding prescribed medications, to me.

I have read and understand the above policies

Patient signature:____________________________________ Date:___________________________

I also hereby grant the clinic permission to release my medical records to the following person(s):

Name:________________________________ Relationship:___________________________

Name:________________________________ Relationship:___________________________