American Indian Health Service of Chicago, Inc.
4081 N. Broadway
Chicago, IL 60613

Acknowledgement of Receipt of Notice of Privacy Practices
&
Consent to the Use and Disclosure of Medical Information for Treatment, Payment and Healthcare Operations

1. We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any questions, please ask to speak to one of our HIPAA Compliance Officers (Holly Spencer or Janyce Agruss) in person or by phone at 773-883-9100. Your signature at the bottom of this page is only acknowledgement that you have received this Notice of our Privacy Practices (NOPP).

2. I consent to the use or disclosure of my medical information by American Indian Health Service of Chicago for the purpose of diagnosing or providing treatment to me, obtaining payment for my treatment or to conduct healthcare operations of the practice.

   I understand that I have the right to request restrictions, for information not discussed in the NOPP, as to how this information is used or disclosed for treatment, payment or healthcare operations and that American Indian Health Service is not required to agree to the restrictions that I may request, but if the practice agrees to a restriction, the practice is bound by the agreement.

   I have the right to revoke this consent, in writing, except where the practice has already made disclosures in reliance on prior consent.

   I understand and have been provided with this practice's NOPP that provides information about how the practice may use and disclose medical information. I understand that I have the right to review the notice prior to signing this consent.

   American Indian Health Service has the right to change the privacy practices that are described in the NOPP. I may obtain a revised NOPP by calling the office and requesting a revised copy be sent in the mail or asking for one when I am in the office.

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Signature of Patient or Authorized Representative Date

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Name of Patient or Authorized Representative