CHICAGO NEUROSCIENCE INSTITUTE

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

For use and/or disclosure of Protected Health Information (PHI)
To carry out Treatment, Payment and Healthcare Operations

_____, hereby states that by signing this Consent,
(Patient Name)

I acknowledge and agree as follows:

The CNI Practice Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my Protected Health Information (PHI) necessary for the Practice to provide treatment to me and also, necessary for the Practice to obtain payment for that treatment and to carry out health care operations. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.

The practice reserves the right to change its privacy practices that are described in its Privacy Notice in accordance with the applicable law.

The Practice's Privacy Notice is provided at the time of the patient's first visit and is always available with the staff at the reception desk. I may also request a copy from this office at any time via US Mail.

This Notice of Privacy Practices also describes my rights and the duties of this office with respect to my Protected Health (PHI).

I have read and understand the forgoing notice and all of my questions have been answered to my complete satisfaction in a way that I can understand.

Name of Patient: _____ Date: _____

Signature: _____ Date: _____

Signature of Legal Guardian: _____ Date: _____

Witness: _____ Date: _____

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