chicago **wellness** center

PATIENT ACKNOWLEDGEMENT

For use and/or disclosure of Protected Health Information (PHI) in order to carry out treatment, payment, and healthcare operations at Chicago Wellness Center (CWC).

I hereby state that by signing this Consent I acknowledge and agree as follows:

1. The Practice's (CWC's) 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) which are necessary for CWC to provide treatment to me, to obtain payment for that treatment, and to carry out its health care operations. CWC explained to me that the Privacy Notice would be available to me in the future at my request. CWC 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 prior to signing this Consent.

2. CWC reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

3. CWC's Notice of Privacy Practices can be provided if asked for at the front desk. I may also request a copy from this office at any time to be sent by US Mail.

4. This Notice of Privacy Practices includes a description of my rights and the duties of CWC with respect to my protected health information.

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

Name (printed): ____

Signature: ______________________________ Date: ___________