Integrative Health Partners LLC

30 N. Michigan Avenue, Suite 1008
Chicago, IL 60602

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

I, _____, understand that as part of my healthcare, Integrative Health Partners originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among health professionals who contribute to my care.
- A source of information for applying my diagnosis information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that Integrative Health Partners reserves the right to change its notice and practices and, prior to implementation, will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that Integrative Health Partners is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I wish to have the following restrictions to the use or disclosure of my health information:

I fully understand and ___accept ___decline the terms of this consent.

_____ _____

Client/Parent/Guardian (circle one) Date

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NOTICE OF PRIVACY PRACTICES

As required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This notice describes how health information about you may be used and disclosed and how you can get access to your health information.

PLEASE REVIEW THIS NOTICE CAREFULLY

A. OUR COMMITMENT TO YOUR PRIVACY.

Our practice is dedicated to maintaining the privacy of your health information. In conducting our business, we will create records regarding you and the diagnosis, treatment and services we provide to you. We are required to:

-Maintain the privacy of your health information.
-Provide you with a notice of our legal duties and privacy practices with respect to information we collect.
-Notify you if we are unable to agree to a requested restriction.
-Accommodate reasonable requests you have to communicate health information by alternative means or at alternative locations.

The terms of this notice apply to all records containing your health information that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times and you may request a copy of our most current Notice.

B. USE AND DISCLOSURES FOR TREATMENT, PAYMENT AND HEALTH OPERATIONS.

The following categories describe the different ways in which we may use and disclose your health information:

1. **Treatment.** We may use your health information to treat you and reach a diagnosis. Additionally, we may disclose your health information to others who may assist in your care.
2. **Payment.** We will use and disclose your health information to bill and collect payment for the services you receive from us. We may provide your insurer with details regarding your treatment to determine if your insurer will cover your treatment. We also may use and disclose your health information to obtain payment from third parties that may be responsible for such costs. Also, we may bill you directly.
3. **Health Care Operations.** We may use and disclose your health information to operate our business. For example we may use and disclose your information to evaluate the quality of care you received from us.
4. **Disclosure Required by Law.** We will use and disclose your health information when we are required to do so by federal, state, or local law.

C. SPECIAL CIRCUMSTANCES FOR DISCLOSURE OF YOUR HEALTH INFORMATION.

The following categories describe unique scenarios in which we may use or disclose your health information:

1. **Public Health Risks.** Our practice may disclose your health information to public health authorities for the purpose of reporting potential violence, potential suicide, emergencies, as well as child or elder abuse, neglect and exploitation.
2. **Lawsuit and Similar Proceedings.** Our practice may use and disclose your health information in response to a state licensing board investigation, a court or administrative order, if you are involved in a lawsuit or similar proceedings. We may disclose your health information in response to a discover request, subpoena or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

3. **Military.** Our practice may disclose your health information if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
4. **National Security.** Our practice may disclose your health information to federal officials for intelligence and national security activities authorized by law.
5. **Workers' Compensation.** Our practice may release your health information for worker's compensation and similar programs.

D. YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION.

You have the following rights regarding the health information we maintain about you:

1. **Confidential Communications.** You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home rather than work. In order to request at type of confidential communication, you must make a written request to your counselor, specifying the requested method of contact of the location where you wish to be contacted. Our practice will accommodate reasonable requests.
2. **Inspection and Copies.** You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records but not including psychotherapy notes. You must submit your request in writing to Integrated Health Partners in order to inspect/obtain a copy of your health information. Our practice may charge a fee for the cost of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another health care professional chosen by us will conduct the review.
3. **Requesting Restrictions.** You have the right to request a restriction in our use or disclosure of your health information for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment of your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction you must make a written request describing the following:
   - the information you wish restricted.
   - whether you are requesting to limit our practice's use, disclosure or both.
   - to whom you want the limits to apply.
4. **Amendment.** You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by our practice. You must make this request in writing and must provide us with a reason to support your request for amendment. Our practice will deny your request if it is not in writing and you fail to provide reason for your request. Also, we may deny your request if you ask us to amend information that is in our opinion (a) accurate and complete; (b) not part of the patient information kept by our practice; (c) not part of the patient information which you would be permitted to inspect or copy, or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.
5. **Accounting of Disclosures.** You have the right to request a list of certain non-routine disclosures our practice has made of your patient information for non-treatment or operations purposes. All requests for this information must be made in writing and must state a time period which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. Our practice may charge you for lists of more than a 12 month period. Our practice will notify you of the costs involved and you may withdraw your request before you incur any costs.
6. **Right to a Paper Copy of this Notice.** You are entitled to receive a paper copy of our notice of privacy practices. To obtain a copy contact your counselor at Integrated Health Partners.
7. **Right to File a Complaint.** If you believe your privacy rights have been violated you may file a complaint with our practice, by contacting your counselor, or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
8. **Right to Provide an Authorization for Other Uses and Disclosures.** Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your health information may be revoked at any time in writing.