

Comprehensive Pain Management Group, LLC

CPMG-MA, LLC

Main Office: 9000 N. Waukegan Rd, Ste 130

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. **PLEASE REVIEW IT CAREFULLY**

YOUR HEALTH INFORMATION

- This notice applies to the information and records we have about your health and services received at our offices.
- We are required by law to give you this notice, it will tell you about the ways in which we may use and disclose health information about you.
- You must sign a consent form to disclose any health information for the following purposes:

TREATMENT We may use health information about you to provide medical treatment. We may disclose health information about you to doctors, nurses, technicians or office staff who are involved in your medical care. Various personnel in our office may share health information about you in order to coordinate care. Examples: phoning in prescriptions to your pharmacy, scheduling procedures or tests. Your authorized family members and other healthcare providers may be a part of your medical care outside of our office and may require information about you that we have.

PAYMENTS We may use health information about you so that the services you receive at our office can be billed to your insurance company or a third party. We may tell your healthcare plan about a treatment plan that may need to be pre-certified and approved, or to determine whether your plan will cover the treatment.

APPOINTMENTS We may contact you to reschedule an appointment or confirm an existing appointment.

OPTIONAL TREATMENTS We may recommend possible treatment options that may be of interest to you. Please notify us if you do not wish to be contacted by phone. This must be done in written consent, signed by you and will remain in your chart until you revoke it in writing. Revocation will be effective at the day and time it is received by our office.

MARKETING AND RESEARCH The practice does not use or disclose any protected health information for marketing purposes. Our practice does not engage in any research activities that require it to use or disclose protected health information.

SPECIAL SITUATIONS

- We may use or disclose health information about you without permission for the following purposes:

TO ADVERT A SERIOUS THREAT TO HEALTH OR SAFETY

We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public.

REQUIRED BY LAW

We will disclose health information about you when required to do so by Federal, State or Local Law.

MILITARY, VETERANS, NATIONAL SECURITY AND INTELLIGENCE

If you are or were a member of the armed forces or part of the national security or intelligence community, we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authorities.

WORKMEN'S COMPENSATION

We may release information about you for Workers' Compensation or similar programs. These programs provide benefits for work-related injuries or illness.

PUBLIC HEALTH RISKS

We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disabilities, report births, deaths, suspected abuses, neglect, non-accidental physical injuries, reactions to medications or problems with products.

HEALTH OVERSIGHT ACTIVITIES

We may disclose health information to a health oversight agency for audits, investigations, inspections or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the healthcare system, government programs and compliance with civil rights laws.

LAWSUITS AND DISPUTES

If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.

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Patient Acknowledgement Form of Physician's Notice of Privacy Practices

I, _____ (patient name) hereby acknowledge receipt of the physician's Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information.

I understand that the physician has reserved the right to change his or her privacy practices that are described in the notice. I also understand that a copy of any "Revised Notice" will be provided to me upon request.

I am also hereby notified; any protected healthcare information (PHI) will be for the sole purpose of continuum of care and is permissible under HIPAA.

Below I have initialed what information I will allow to be released:

- My entire medical records/history (includes all listed below)**
- Laboratory reports
- Mental health treatment records
- Alcoholism treatment records
- HIV/AIDS Acquired Immune Deficiency Syndrome records
- X-ray reports
- Drug abuse records
- Operative notes
- Prescription History

I give my permission for Comprehensive Pain Management Group to speak to the following people regarding my medical condition for treatment:

_____	_____	_____
Name	Relationship	Phone
_____	_____	_____
Name	Relationship	Phone

Any messages regarding my appointments, medications or test results **MAY/MAY NOT** be left on my answering machine, cell phone or e-mailed to me directly:

Home Phone: _____ Cell Phone: _____ E-mail _____

PLEASE: Provide your pharmacy information so that we may electronically prescribe.

Pharmacy name: _____ **Phone:** _____ **Fax:** _____

I understand that this information is updated yearly and that I may revoke or change this authorization by written request. Until this is done, this authorization is valid and will be kept with my medical records.

Please Sign: _____ (Patient or Legal Guardian) _____ (date)

(or) I do not authorize any information regarding my condition, medication or tests to be discussed with anyone.

_____ (Patient or Legal Guardian) _____ (date)