

**CHICAGO FAMILY ASTHMA & ALLERGY, S.C.**  
**PRIVACY PROCEDURES**

Privacy Policy: Our practice recognizes and respects the fact that the patient has a right to inspect and obtain a copy of his/her Protected Health Information (PHI).

**Privacy Procedures to accomplish this Privacy Policy**

- The office will provide the front office staff with an original form for patients to complete when the patient desires to inspect and copy his/her PHI.
- The office will photocopy and make available to patients the form to Inspect and Copy PHI.
- The office will respond to patients' requests and questions concerning inspecting and copying their PHI. In addition, the front office staff will distribute the form to the patients upon their request.
- Once the patient completes the form, the office should forward the form to the physician for review.
- Once the patient has submitted his/her request in writing (using the practice's form is optional), the office must verify that the patient's signature matches his/her signature on file.
- The physician must review the patient's request and direct the appropriate employee to respond to the patient within 30 days from the date of the request. The practice can request an additional 30-day extension as long as the request is made to the patient in writing with the reason for the delay clearly explained.
- The practice should agree to all reasonable requests. If access is denied, the practice must provide the patient with an explanation for the denial as well as a description of the patient's review appeal.
- When the patient has requested to inspect their PHI and his/her request has been accepted, the physician, or other authorized practice representative, should accompany the patient to a private area to inspect his/her records. After the patient inspects the record, the physician, or designated employee, will note in the record the date and time of the inspection, and whether the patient made any requests for amendments or changes to the record.

**Chicago Family Asthma & Allergy, S.C.**  
**PATIENT CONSENT FOR USE AND DISCLOSURE**  
**OF PROTECTED HEALTH INFORMATION**

With my consent, Chicago Family Asthma & Allergy, S.C. (“the practice”) may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to our Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent.

Chicago Family Asthma & Allergy, S.C. reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Compliance Officer: Aaron Donnell, MD, 2551 N Clark St, Suite 201, Chicago, IL 60614.

With my consent, and in accordance with Illinois law, Chicago Family Asthma & Allergy, S.C. staff may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including test results among others.

With my consent, Chicago Family Asthma & Allergy, S.C. may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. With my consent, the practice may e-mail to my designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that the practice restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to the practice’s use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, the practice may decline to provide treatment to me.

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Patient’s Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Patient or Legal Guardian