

# METRODOCS

## Receipt of Notice of Privacy Practices Form and Consent for Release and Use of Confidential Information

I acknowledge receipt of Metrodocs' 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 Metrodocs has reserved the right to change its Privacy Practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available upon my request or at the first date of treatment following the change.

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

\_\_\_\_\_  
*Date*

I hereby give my consent to Metrodocs, S.C. to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). I understand I have the right to review the Notice of Privacy Practices prior to signing this consent.

With my consent, Metrodocs may mail to or call my home in person or leave a message on voice mail in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, clinical care and any references to test results.

When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that Metrodocs has acted in reliance upon this authorization. My written revocation must be submitted to Metrodocs' Privacy Officer at 431 Lakeview Court, Mount Prospect, Illinois 60056.

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

\_\_\_\_\_  
*Relationship to Patient*

\_\_\_\_\_  
*Patient's Name*

\_\_\_\_\_  
*Date*

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