HIPAA CONSENT
PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Hinsdale Pharmacy Associates, Inc. dba Elm Plaza Pharmacy (EPP)

EPP provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

With my consent, **Elm Plaza Pharmacy (EPP)** may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to **EPP**'s 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. **EPP** reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **EPP** at 908 N. Elm Street, Suite 100, Hinsdale, IL 60521.

With my consent, **EPP** may call my home or other designated location and leave a message on voicemail or in person in reference to any items that assist **EPP** in carrying out TPO, such as appointment reminders, insurance items and calls pertaining to my clinical care.

With my consent, **EPP** may mail to my home or other designated location any items that assist **EPP** in carrying out TPO, such as patient statements, collection letters and any other correspondence or related materials.

However, **EPP** 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 **EPP**'s use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing to the extent that **EPP** has already made disclosures in reliance upon my prior consent. If I do not sign this consent, **EPP** may decline to provide treatment to me.

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- **EPP** has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- **EPP** reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the uses of their information but **EPP** does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- **EPP** may condition receipt of treatment upon the execution of this consent.

_____ _____

Signature of Patient of Legal Guardian | Print Name of Patient or Legal Guardian

_____ _____

Patient's Name | Date