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**NOTICE OF PRIVACY PRACTICES  
 PATIENT ACKNOWLEDGEMENT FORM**

Your privacy, including the confidentiality of your health care information is very important to us. Additionally, Federal law prohibits the unauthorized release of certain medical and health information. Before our office can use your Protected Health Information for treatment, payment, and health care operations, you must acknowledge that you have received a copy of our Notice of Privacy Practices informing you how our office may use and disclose your Protected Health Information.

You should carefully read our Notice of Privacy Practices to understand how we take steps to protect the privacy and confidentiality of your Protected Health Information. Federal law gives you certain rights regarding the use and disclosure of your Protected Health Information. These rights include: (1) the right to request that we restrict how your Protected Health Information can be used or disclosed for treatment, payment, or health care operations; (2) the right to receive confidential communications of your Protected Health Information, if applicable; (3) the right to inspect and copy your Protected Health Information; (4) the right to amend your Protected Health Information; and (5) the right to receive an accounting of the disclosures of your Protected Health Information.

By signing this form, you acknowledge that you have received a copy of our Notice of Privacy Practices concerning the use and disclosure of your Protected Health Information.

To respect your privacy, please tell us which of the following numbers we should call to communicate with you regarding Appointment Reminders, Lab Results, etc. **Only list the phone number or numbers you want us to call.**

Home _____	May we leave a message?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Work _____	May we leave a message?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Cell Phone _____	May we leave a message?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Other _____	May we leave a message?	<input type="checkbox"/> YES	<input type="checkbox"/> NO

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Signature \_\_\_\_\_ Date \_\_\_\_\_

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Print Name of Patient/Legal Representative \_\_\_\_\_

( see page 2 )

You may want us to share Health Information with a person who is involved in your medical care, such as your family or a close friend. Please list ALL such people that you would allow us to disclose your Health Information to:

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Name Relationship

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Name Relationship

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Name Relationship

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Name Relationship

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Name Relationship

X

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Patient Signature

Date