ADAM M. RUBINSTEIN, M.D.
INTERNAL MEDICINE
250 CENTER DRIVE SUITE 201
VERNON HILLS, IL 60061
PH: 847-247-0300 FAX: 847-247-8011
TAX ID: 36-4308880

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT CONSENT FORM

Purpose: Consent For Use Of Disclosure Of Information For Treatment, Payment Or Health Care Operations

A. Consent to use or disclose health information for treatment, payment or health care operations

I hereby authorize Adam Rubinstein, M.D., S.C., to use or disclose my individually identifiable health information for the purposes of treatment, payment or health care operations. This consent shall cover any of my individually identifiable health information that Adam Rubinstein, M.D., S.C. may maintain or receive. I understand that I am signing this consent voluntarily. No individual has coerced me into signing this consent and I am providing this consent under my own free will.

B. Review of privacy notice

I have read and understand the Privacy Notice of Adam Rubinstein, M.D., S.C. I further understand that the Privacy Notice provides a more complete explanation of the uses or disclosures of my individually identifiable health information. I acknowledge that Adam Rubinstein, M.D., S.C. has reserved the right to change its privacy practices as they are described in the Privacy Notice. I understand that I may receive a copy of any future revised Privacy Notices by contacting the Chief Privacy Officer of Adam Rubinstein, M.D., S.C. at (847) 247-0300.

C. Right to revoke consent

I understand that I have the right to revoke in writing this consent at any time to the extent that Adam Rubinstein, M.D., S.C. has not taken action in reliance on this consent.

D. Right to restrict use or disclosure

I understand that I have the right to restrict how Adam Rubinstein, M.D., S.C. may use or disclose my individually identifiable information to carry out treatment, payment or health care operations. I also understand that the law does not require Adam Rubinstein, M.D., S.C. to agree to such restrictions (except for any written revocation Adam Rubinstein, M.D., S.C., Chief Privacy Officer receives); however, if Adam Rubinstein, M.D., S.C. agrees to any restrictions, then Adam Rubinstein, M.D., S.C. shall be legally bound to abide by such restrictions.

ADAM M. RUBINSTEIN, M.D.
INTERNAL MEDICINE
250 CENTER DRIVE SUITE 201
VERNON HILLS, IL 60061

Please initial **one** of the following:

_____ I have not requested any restrictions on the use or disclosure of my individually identifiable health information when Adam Rubinstein, M.D., S.C. uses such information to carry out treatment, payment or health care operations.

_____ I request the following restrictions on my individually identifiable health information when Adam Rubinstein, M.D., S.C. uses such information to carry out treatment, payment or health care operations. I understand that I may be asked for payment of any office visits that contain information that I have requested be restricted. I request the following restrictions:

_____

_____

E. Signature

By signing below, I acknowledge and affirm the statements in this consent form.

_____
Signature of patient/personal representative

_____
Printed name of patient/personal representative

_____
Date