



Dr. Timothy J. Ryan
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Consent for Release and Use of Confidential Information and
Receipt of Notice of Privacy Practices Form

I, _____, hereby give my consent to Dr. Timothy Ryan and his staff to use or disclose all
information contained in the patient record of _____ for the purpose of carrying out
treatment, payments, or health care operations.

I acknowledge receipt of the physician's 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 the physician has reserved a right to change his privacy practices that are described in
the Notice. I also understand that a copy of any Revised Notice will be available to me at the next
appointment.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this
consent at any time by giving written notice of my desire to do so, to the physician. I also understand
that I will not be able to revoke this consent in cases where the physician has already relied on it to use
or disclose my health information. Written revocation of consent must be sent to the physician's office.

Signed: _____ Date: _____

If you are not the patient, please specify your relationship to the patient

CONFIDENTIALTY OF INFORMATION

To ensure the confidentiality of my medical records, I am allowing the following parties (spouse,
family member, other responsible party) to discuss my treatment that I am receiving from Dr. Ryan
and his medical staff.

Table with 3 columns: Name, Address, Phone. Multiple rows for listing parties.

Patient signature

PRICES/BILLING

My signature below constitutes my acknowledgement that I have read and understand the
Prices/Billing sheet.

Patient signature



Notice of Privacy Practices

In 1996, Congress passed the Health Insurance Portability and Accountability Act (HIPPA). This law requires our office to develop a policy on how information on your health can be used or disclosed. We are also required to share this policy with you. _____ (initials)

This notice describes how medical information about you may be used and disclosed and how you can gain access to this information. Please review it carefully.

USES AND DISCLOSURES OF YOUR HEALTH INFORMATION

Your health information may be disclosed during the following instances:

Treatment: Your health information may be disclosed to a physician, physician's staff, or other healthcare providers providing treatment to you. _____ (initial)

Payment: Your health information may be used to obtain payment for services rendered to you. Examples include, but are not limited to, insurance companies, collection agencies, audits, billing agencies, and utilization review. _____ (initial)

Persons Involved in Your Care: Your health information may be disclosed when allowing a person to pick up samples of medications, medical notes, medical disability forms, prescriptions, and medical records already released to you. _____ (initial)

Healthcare Operations: Your health information may be used regarding pre-certification or predetermination of a surgical procedure, verifying benefits, and any other information requested by your insurance company. _____ (initial)

Your Authorization: In addition to our use of your health information for treatment, payment of health care operations, you may give written authorization to use your health records or to disclose it to anyone for any purpose. IF you give us an authorization, you may in writing revoke it at any time. Information will be released within 30 days from the date of your request. _____ (initial)

To Your Family: Your health information may be disclosed to your family only if needed to help you with your healthcare or with payment for your healthcare services. _____ (initial)

Employer and Disability: Your healthcare information may be disclosed to your employer and on all disability forms related to time off. All information will have to be picked up in our office, unless authorized to fax it at your request. _____ (initial)

Communication: Your healthcare information may be used to provide you with appointment reminders, schedule changes, reports, and surgical information. We may use voicemail and answering machines at home and at work when necessary. Information may have to be left on your cell telephone if that is our means of reaching you. _____ (initial)

The only time we will disclose your protected health information without your written request would be for public health requirements or court orders. _____ (initial)

Patient rights: You can always look at or get copies of your health information. A written request must be made to obtain access to your health information. A list of instances in which we disclosed your health information for any reason other than treatment, payment and healthcare operations may be obtained for the last 6 years. _____ (initial)

Restrictions: You can always request we place restrictions on your health information. We will be happy to agree to this restriction if possible. _____ (initial)

Questions and complaints:

If you want more information about our privacy practices, or have questions or concerns, or if you are concerned that your privacy rights have been intruded upon, or you disagree with a decision we made your health information, you may contact the office manager at 847.856.2534.