Acknowledgment of Receipt of Privacy Notice in Combination with Voluntary Consent

Acknowledgment:

As a patient of the Company, I have been provided with its **Notice of Privacy Practices,** which describes how medical information about me may be used or disclosed and informs me of my individual privacy rights.

I acknowledge that I have received the Notice of Privacy Practices.

Consent:

I give consent for medical information about me to be used and disclosed for purposes of treatment, payment or health care operations. I understand that the privacy regulations allow the Company to use or disclose my medical information for these purposes and that my consent is not required. The Company is obtaining my consent to provide additional assurance regarding the privacy of my medical information.

I understand that I have the right to make a request to revoke this consent and instead request a restriction on the use of my medical information at any time. I further understand that the Company may choose not to agree to the request for a restriction on the uses or disclosures of my medical information for purposes of treatment, payment or health care operations.

To make a request to revoke my consent I must complete and sign a "Request to Restrict Uses and Disclosures of Protected Health Information" form and return it to the Company Designee. I may obtain a copy of the form from Fox Valley Medical Associates, Ltd at (630) 879-5700.

______________________________________ ________________________
Signature of Patient or Personal Representative Date

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Written name of Patient or Personal Representative

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Description of Personal Representative's authority to act on Patient's behalf

Please sign and return to:
Fox Valley Medical Associates, Ltd
1180 W. Wilson, Suite E
Batavia, IL 60510