North Suburban Pulmonary and Critical Care Consultants

9201 Waukegan Rd
Morton Grove, IL 60053
P: 847-759-4770
F: 847-759-8824
W: nspccc.com

Elizabeth M. Klein, M.D., F.C.C.P.
Arvey M. Stone, M.D.
Bhaven Shah, M.D.
Michael Katsoulis, D.O.
Damaris Stoia, FNP-BC

Insurance Consent and Release

I hereby authorize North Suburban Pulmonary and Critical Care Consultants, S.C. and its agents to release to and discuss with my insurance company or family physician any information related to treatment by said North Suburban Pulmonary and Critical Care Consultants, S.C. I authorize that benefits be paid directly to them. I understand that payment of charges is not contingent on any insurance payment from my insurance company and that I am responsible for payment of any unpaid balance.

Initials: _____

Consent for Release and Use of Confidential Information and Receipt of Notice of Privacy Practices

I hereby give my consent to North Suburban Pulmonary and Critical Care Consultants, S.C. to use or disclose, for the purpose of carrying out treatment, payment or health care operations, all information contained in my patient record.

I acknowledge receipt of the physician's Notice of Privacy Practices. The Notice of Privacy Practices provides detailed information about how North Suburban Pulmonary and Critical Care Consultants, S.C. may use and disclose my confidential information.

I understand that the physician has reserved a right to change his or her privacy practices that are described in the notice. I also understand that a copy of any revised notice will be provided to me or made available at the office of North Suburban Pulmonary and Critical Care Consultants, S.C.

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.

Initials: _____

Patient: _____

Signature: _____

Date: _____

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

_____

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Inspiring medicine. Changing lives.

Specially Protected Health Information Authorization Form

Authorization to use and/or disclose protected health information in the Electric Health Information Exchange.
I authorize this practice to use and/or disclose a copy of my protected health information in the Electric Health Information Exchange (eEHX) for the purpose of coordinating my medical care amongst my healthcare providers. I understand that including this information in eEHX enables any provider with authorized access to the eEHX to review my protected health information, including the following specially protected health information:

I acknowledge that I have been given sufficient information and have had the opportunity to have my questions answered about the Electric Health Information Exchange (eEHX).

I understand that future withdrawal of permission to include this information in the Electric Health Information Exchange (eEHX) will be effective except to the extent action has already been taken in reliance on this permission. When I withdraw my protected health information will be inactivated and the eEHX and will no longer be able to be accessed. This permission will expire if the eEHX program is discontinued.

I understand that my eligibility for treatment or any health care benefits cannot be conditioned on whether I sign this authorization form. However, to the extent I have indicated "YES" to the sharing of my protected health information, I understand that an Electric Health Information Exchange record will be available to other eEHX authorized users.

Authorized date(s) or date range: _____

Printed name of Patient/Representative: _____

Signature of Patient/Representative: _____

Date: _____

Authorization of Representative:

I, _____, do hereby state that I am authorized to sign this permission

on behalf of the patient on the following basis: Relationship to patient: _____.

[A signed copy of this permission will be provided to the patient/representative.]