ANNITA JOHN, MDPC

10237 S Western Ave, Chicago, IL 60643. PH:(773) 238-1616

MEDICAL INFORMATION PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED BY ANNTTA JOHN MD., AND HOW YOU CAN GET ACCESS TO '111.1S INFORMATION. PLEASE REVIEW THIS CAREFULLY.

Effective Date: Date on Patient's Acknowledgement of HTPAA Notice.

1. **PURPOSE OF THIS NOTICE:** We consider any information that concerns your health, health care or payment for that care to be confidential and protected information. This notice describes our privacy practices; specifically how we use and disclose your medical information and what rights you have with respects to this information. This information includes your name, address, other identifying data and information on your health or the health services that have been or may be furnished to you. WE require all of our employees, volunteers and independent contractors to comply with these privacy practices.

2. **THE USE AND DISCLOSURE OF MEDICAL INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS**: By law we are allowed to use and disclose your medical information for most purposes related to your medical treatment(s), the payment for your medical treatment(s), and our health care operations of other covered entities to which we disclose your medical information.

> Treatment means the provision, coordination or management of health care related services by or involving one or more health care providers, such as the coordination of consultants and referrals. For example, we can share most medical information regarding your health condition with another provider as part of a consultation. Please note that by law, certain medical information, such as psychotherapy notes, generally may not be used or shared even when it is related to your treatment, unless we obtain an authorization from you to use or release that information.
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> We may contact you to notify you regarding treatment alternatives or other health related benefits and services that may be of interest to you. We may also contact you to remind you to make, or that you have already made an appointment. **PLEASE CONTACT OUR OFFICE PRIOR TO YOUR SCHEDULED APPOINTMENT, IF YOU ARE UNABLE TO KEEP YOUR SCHEDULED APPOINTMENT THERE WILL BE A $25.00 NO SHOW FEE FOR ALL MISSED APPOINTMENTS**.

Signature: _____ Date: _____