SONALI P. MAJMUDAR, MD

ADULT AND PEDIATRIC
ALLERGY, ASTHMA AND IMMUNOLOGY SOLUTIONS

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

I understand that as part of my healthcare, Sonali P. Majmudar MD, originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, billing information and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionsals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third party payer can verify that services billed were actually provided
- A tool for routine health care operations such as assessing quality and reviewing the competence of healthcare professionals, and
- A means by which payment for services can be made

I understand and have been provided with a NOTICE OF INFORMATION PRACTICES that provides a more complete description of information uses and disclosures. I understant that I have the right to review the notice prior to signing this consent. I understand that the origanizaton reserves the right to change its notice and practies and will provide a copy of any revised notice. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understant that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I have the right to request restrictions on the use of my health information. I understand that my request is not agreed to by Sonali P. Majmudar MD, unless Sonali P. Majmudar MD agrees to the request in writing.

I understand that for convenience or necessity I would like my health information available to the following friends or family members:

_____ _____

_____ _____

_____ _____

I fully understand and accept the terms of this contract.

_____ _____

Patient Signature Date

1585 N. BARRINGTON ROAD, SUITE 503, HOFFMAN ESTATES, ILLINOIS 60169
600 S. RANDALL ROAD, 2ND FLOOR, ALGONQUIN, ILLINOIS 60102
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