



Psychological Services of Chicago
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Notice of Privacy of Health Information

At Psychological Services of Chicago, (PSC), we care about our patient's privacy and strive to protect the confidentiality of your personal health information. The federal legislation requires that we issue you the Notice of Privacy Practices (NPP), abide by the terms and inform you of

HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

This form is an agreement between you, the undersigned, and PSC. When we examine, test, diagnose, treat, or refer you, we will be collecting what the law calls "protected health information" (PHI). We need to use this information in our office to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others to arrange for your treatment and payment for the services you receive and other related administrative duties supporting your treatment.

You have rights related to inspecting and copying your PHI that we maintain, amending or correcting that information, obtaining and accounting for our disclosures of your health information, requesting that we communicate with you confidentially, requesting that we restrict certain uses and disclosures of your PHI and filing a complaint if you think your rights have been violated.

By signing this form, you are also agreeing to let us use your PHI and to send it to others for the purposes described above. Your signature below acknowledges that you have read or heard our Notice of Privacy Practices, which explains in more detail what your rights are and how we can use and share your information.

If you do not sign this form agreeing to our privacy practices, we cannot treat you. In the future, we may change how we use and share your information, so we may change our Notice of Privacy Practices. If we do change it, you can get a copy from our website, www.psychotherapybypsc.com, or by calling us at (312) 909-6766. The most current notice in effect is indicated at the bottom of this consent form.

After you have signed this consent, you have the right to revoke it by writing to PSC. We will then stop using or sharing your PHI, but we may already have used or shared some of it, which we cannot change.

Patient Signature (12 years old and older) Date Witness Signature Date

Patient/Parent/Guardian Signature (Under 12 years old) Date

July 1, 2012