Greg S. Cohen M.D., LLC
676 N Saint Clair Street, Arkes Pavilion 1750, Chicago, IL 60611
Phone: 312-695-4452 Fax: 312-695-4453

Consent for Workup and Treatment

I have come to Greg S. Cohen MD, LLC (hereinafter referred to as the **"Practice**") for the purpose of diagnosis and treatment that may include laboratory tests, x-rays, injections, additional diagnostic procedures, referrals and any gathering of information that is necessary to my care. I understand that no guarantees have been made to me regarding the outcome of my diagnosis or treatment.

Acknowledgement of the Use of an Electronic Health Record

I acknowledge that the Practice is using an electronic health record information system (the "**EHR System**"), in coordination with Northwestern Memorial Hospital. The collection and use of all information through the EHR System is primarily for the purpose of treatment of patients by NMH, this medical practice and other medical practices in a clinically integrated care setting. All information collected through the EHR System may also be shared with, and used by, NMH and certain other hospitals, academic institutions, and health care providers that perform medical or research activities on NMH's campus or otherwise in conjunction with NMH (including, but not limited to, Northwestern University, the Feinberg School of Medicine, Children's Memorial Hospital, and the Rehabilitation Institute of Chicago) for the following related activities, including without limitation: (a) conducting peer review; (b) promoting quality assurance; (c) mortality and morbidity analysis; (d) conducting utilization review; (e) evaluating and improving the quality of care; (f) promoting and maintaining professional standards; (g) examining costs and maintaining cost control; (h) conducting medical audits; (i) assisting the medical staff membership and credentialing process; (j) performing data quality management; (k) improving the efficiency and effectiveness of healthcare; (l) conducting research; (m) extracting data from the EHR System and any related database and incorporating it into a data warehouse maintained by NMH.

Retention of Information

The Practice may record and retain medical and other information either on paper, electronically, or other physical forms.

Release of Information

I authorize the release of my medical or financial information, orally, on paper, or electronically to the Practice. I hereby give my consent to the Practice to use or disclose, for the purpose of carrying out treatment, payment or health care operations, all information contained in my patient record. I also hereby authorize payment of insurance benefits otherwise payable to me, directly to the Practice.

Access to Prescription Medication History from External Sources

I authorize the Practice to access my prescription medication history from external sources.

Receipt of Notice of Privacy Practices

I acknowledge receipt of the Practice's Notice of Privacy Practices. The Notice of Privacy Practices provides detailed information about how the Practice may use and disclose my confidential information.

I understand that the Practice has reserved the right to change the privacy policies that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available upon request.

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 Practice. I also understand that I will not be able to revoke this consent in cases where the Practice has already relied on it to use or disclose my health information.

Policy on Missed Appointments and Phone Call / email Communication

If I cannot keep an office appointment, I must provide 1 business day notice. If I cannot keep a procedure appointment (e.g. colonoscopy and/or upper endoscopy), I must provide 3 business days notice. If I miss my appointment and do not provide appropriate notice, the Practice reserves the right to charge a missed appointment fee. I authorize the Practice to communicate with me via email. Email communication with the Practice is optional, and the Practice reserves the right to suspend or terminate it at any time. I understand that email communication is not for emergency purposes. I acknowledge and understand that any information conveyed using email is not protected and may be viewable in the public domain. I may be charged a fee for phone calls and emails to the doctor.

Patient Signature: ____