

**Traveler's Health & Immunization Center  
7900 N. Milwaukee Ave., Suite 231  
Niles, IL 60714  
(847) 663-9500  
www.travelmed.net**

**Consent to the Use and Disclosure of Protected Health  
Information for Treatment, Payment and/or Healthcare Operations**

I understand that Traveler's Health and Immunization Center, S.C. originates and maintains protected health information for the purpose of treatment, payment and healthcare operations.

I understand that since Traveler's Health and Immunization Center, S.C. has the right to change their Privacy Practice in accordance with the law, the terms contained in the Notice of Privacy Practices ("Notice") may change as well. Traveler's Health and Immunization Center, S.C. will provide a copy of the most updated Notice in the office. They are also required to provide me a copy of the Notice on my first visit as required by law. I will also be provided a copy of the Notice upon request.

As more fully explained in the Notice, you have the right to request restrictions on how Traveler's Health and Immunization Center, S.C. can use or disclose your protected health information for treatment, payment and/or healthcare operations. Traveler's Health and Immunization Center, S.C. is not required to agree to your request. If your request is approved, Traveler's Health and Immunization Center, S.C. is required to comply with your restriction unless the information is needed for emergency treatment. Restrictions should be noted on the form attached. These restrictions will stay in effect until otherwise terminated. Any other practitioner who provides coverage for Traveler's Health and Immunization Center, S.C. is required to use or disclose your protected health information as stated in the notice.

I understand that I have the right to revoke this consent provided I do so in writing, except to the extent that Traveler's Health and Immunization Center, S.C. has already used or disclosed the information relied upon by this consent.

**I acknowledge receipt of Traveler's Health and Immunization Center, S.C. Notice of Privacy Practices. I understand this document provides additional information about the use and disclosure of my protected health information.**

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Signature of patient or legal guardian

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Date

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Name of patient or legal guardian

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Relationship to patient