Rachel O'Mara, MD, LLC
Personal Physician

Consent for Care

I acknowledge that my medical records are part of a larger system of Northwestern. Specifically,

> The patient acknowledges that this 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.

I give permission to the practice to access my prescription medications from my pharmacy.

I have reviewed the Rachel O'Mara, MD, LLC:

- Financial Policies
- Notice of Privacy Policies
- Patient Rights and Responsibilities

and I understand that the most current version of these policies can be found on the practice website: RachelOMaraMD.com. I understand that I have the opportunity to review a laminated copy at each office visit as well as request and receive a paper copy.

I certify that I have read and understand the policies and agree to all terms and conditions as stated above.

Name: _____ Date: _____

676 N. Saint Clair Street, Suite 1740
Chicago, IL 60611-2963
RachelOMaraMD.com

312.926.0444
fax 312.926.2797
office@RachelOMaraMD.com