

GASTROENTEROLOGY ASSOCIATES, P.C.

Privacy Practices Acknowledgement

I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can be used to:

- * conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in my treatment, directly or indirectly
- * obtain payment from insurance companies
- * conduct normal healthcare operations such as quality assessments

I acknowledge that I have had the opportunity to read the Notice of Privacy Practices of Gastroenterology Associates, P.C. and have had the opportunity to ask questions about the information provided in the notice and that I may request a paper copy of the Notice. I understand that I may request in writing that you restrict how my private health information is used or disclosed. I further understand that you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

PATIENT CONSENT TO USE AND DISCLOSURE of
Protected Health Information for treatment, payment and healthcare operations

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect your privacy. We also want you to know that we support your full access to your personal medical record. You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you, should you choose to refuse to disclose your Protected Health Information (PHI). You may not revoke actions that have already been taken, however.

I consent to treatment by GASTROENTEROLOGY ASSOCIATES, P.C. and to use and disclosure of my PHI. I understand this includes:

- * conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in my treatment, directly or indirectly
- * obtain payment from insurance companies
- * conduct normal healthcare operations such as quality assessments

I understand that I may request in writing that you restrict how my protected health information is used or disclosed. I also understand that you are not required to agree to my requested restrictions, but if you do agree, you are bound to abide by such restrictions. I understand that I may revoke this consent in writing at any time.

Signature of patient or patient's representative

Date

Printed name of patient or patient's representative

Relationship

I hereby give my permission to the person(s) listed below to receive verbal information about my care and treatment.

Name

Relationship
