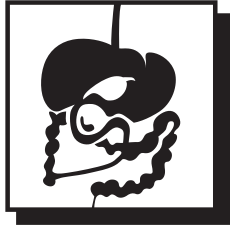

THE
GASTROENTEROLOGY
GROUP

ACKNOWLEDGEMENT FORM

Our notice of Privacy Practices provides information about how we may use and release protected health information about you. You have the right to review our Notice before signing this form. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy by writing our practice or requesting a copy from our front desk staff.

You have the right to request that we restrict how protected health information about you is used or released for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and release of protected health information about you for treatment, payment and health care operations as described in our Notice. You have the right to revoke this consent, in writing, except where we have already made releases in reliance on your prior consent.

Patient Name

(Print) ______________________________

(Signature) ______________________________

Date: ______________________________

Witness: ______________________________

AUTHORIZATION TO RELEASE OR USE INFORMATION FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS

I hereby authorize the release or use of my protected health information ("**PHI**") and medical record information by The Gastroenterology Group (the "Practice") in order to carry out treatment, payment, or health care operations. These disclosures may be by phone, mail, fax or electronic transmission. You should review the Practice's **Notice of Privacy Practices** for a more complete description of the potential release and use of such information, and you have the right to review such Notice prior to signing this Consent Form.

If you allow a third party other than one our practice's physicians or staff to be in the exam room while one of our physicians or staff is examining you or discussing your care, treatment or medical condition with you, by signing this Consent form you are consenting to the disclosure of your PHI to that third party.

We reserve the right to change the terms of its Notice of Privacy Practices at any time. If we do make changes to the terms of its Notice of Privacy Practices, you may obtain a copy of the revised Notice.

You retain the right to request that we further restrict how your protected health information is released or used to carry out treatment, payment, or health care operations. Our practice is not required to agree to such requested restrictions; however, if we do agree to your requested restriction(s), such restrictions are then binding on the Practice.

I acknowledge and agree that the Practice may disclose my protected health information and medical record information to the following individuals: (please initial line and write in name of individual)

____Spouse____________________ **____Parent______________________**

____Child______________________ **____Legal Guardian___________________**

____Other_____________________ **____Other________________________**

I agree that the Practice may also disclose the following types of information contained in my medical record (**please initial** the appropriate categories listed below):

_______ HIV/AIDS Information
_______ Mental Health Information
_______ Substance Abuse Information
_______ Sexually Transmitted Disease Information
_______ If Patient is under the age of eighteen (18), Pregnancy Information

I agree and consent to the Practice releasing information to me in the following alternative manner(s) (please initial the appropriate spaces below):

______ Via regular mail ______ Via email address ________________________________

______ Via telephone

______ Via fax to my designated fax number which is: __________________________

______ Via home answering machine

______ Via work voice mail

At all times, you retain the right to revoke this consent. Such revocation must be submitted to the Practice in writing. The revocation shall be effective except to the extent that the Practice has already taken action based on the prior Consent.

The Practice may refuse to treat you if you (or an authorized representative) do not sign this Consent Form. If you (or authorized representative) sign this Consent and then revoke it, the Practice has the right to refuse to provide further treatment to you as of the time of revocation (except to the extent that the Practice is required by law to treat individuals).

I have read and understand the information in this consent. I am the patient or the authorized party to act on behalf of the patient to sign this document verifying consent to the above terms.

By signing below, I acknowledge and agree to the above conditions.

Date: _______________ Time: _______ AM/PM

____
Signature of Patient or authorized representative

____
Please print Name

- Please explain Representative's relationship to the Patient and include a description of Representative's authority to act on behalf of the Patient:

  ____

  ____

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