Digestive Healthcare of Georgia , P.C.

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Patient Name: _____

DOB:_____/_____/_____ Social Security #:_____/_____/_____

I understand that, as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plan for future care or treatment. I hereby give my consent for Digestive Healthcare of Georgia, P.C. to use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). I have been given the opportunity to read the "Notice of Privacy Practices" which provides a more complete description of such issues and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing the consent. Digestive Healthcare of Georgia reserves the right to revise it's Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to *Digestive Healthcare of Georgia Privacy Officer at 95 Collier Rd., Suite 4075, Atlanta GA 30309.*

I reserve the right to restrict information, medical or financial, that Digestive Healthcare of Georgia is authorized to release and/or designate specific individual/entities authorized and/or discuss the information regarding my care. If I choose to restrict the release of information and/or the individuals/entities that may receive this information from Digestive Healthcare of Georgia, I may do so by completing the "Authorization to Restrict/Release Personal Health Information" form that will be placed in my permanent chart.

With this consent, Digestive Healthcare of Georgia may call my home or other alternative location as specified by me, and leave a message in person or on voice mail regarding any items that assist the practice in carrying out TPO, such as appointment reminders, insurance inquiries/information ,and/or calls pertaining to my clinical care, including test results (laboratory, X-rays, etc).

I may revoke this consent in writing to the extent the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Digestive Healthcare of Georgia may decline to provide treatment to me. By signing this form, I am consenting Digestive Healthcare of Georgia's use and disclosure of my PHI to carry out TPO as permitted by the Health Information Portability and Accountability Act (HIPAA)

I understand that information contained in my medical chart serves as:

- a basis for planning my care and treatment
- a means of communication among the many healthcare professionals who contribute to my care.
- a source of information for applying my diagnosis and surgical information to my bill.
- a means by which a third party can verify that services billed were actually provided.
- a tool of routine healthcare operations, such as assessing care quality and reviewing the competence of healthcare professionals.

_____ _____/_____/_____

Signature of Patient, Guardian or Legal Representative Date

_____ _____/_____/_____

Witness Signature Date