THE CENTER FOR COLON AND DIGESTIVE DISEASE

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

1. This is to inform you that The Center for Colon and Digestive Disease, P.C. may use and disclose your health information that identifies you and that consists of your past, present, or future physical or mental health or condition, the provision of your healthcare; and the past, present, or future payment of your healthcare (this health information is referred to herein as "protected health information").

2. The use and disclosure of your protected health information will be to carry out treatment, payment, and healthcare operations for The Center for Colon and Digestive Disease, P.C.

3. You have the right to request that The Center for Colon and Digestive Disease, P.C. be restricted from using or disclosing your protected health information in carrying out treatment, payment, or health care operations; however, The Center for Colon and Digestive Disease, P.C. is not required to agree to your requested restrictions. If The Center for Colon and Digestive Disease, P.C. does agree to your requested restrictions, then it will comply with your request.

4. You have the right to revoke this consent. This revocation must be made in writing to The Center for Colon and Digestive Disease, P.C. This revocation will be valid except to the extent that The Center for Colon and Digestive Disease, P.C. has taken action in reliance on this consent.

5. I, the undersigned, consent to receive telephone calls from The Center for Colon and Digestive Disease, P.C. at any of the telephone number(s) I have supplied including wireless/cellular number(s). I understand that such calls may be generated by an automated dialing system and that I may be charged a fee for such calls by my wireless carrier.

6. Further, I hereby authorize and give my consent to The Center for Colon and Digestive Disease, P.C. to communicate any of my protected health information to the following persons:

NAME	RELATIONSHIP

REFERRING PHYSICIAN	ADDRESS

- ❑ I acknowledge receipt of The Notice of Privacy Practices form which details how protected health information may be used and disclosed and how I may access that information.

_____ _____ _____
Patient Name (PLEASE PRINT) Date Patient Signature

Patient Date of Birth_____ Patient Social Security Number_____

_____
Signature (AUTHORIZED REPRESENTATIVE)