GASTROENTEROLOGY ASSOCIATES, INC.

HIPAA Patient Consent Form

Our *Notice of Privacy Practices* provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing the consent. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by requesting one from our Receptionist.

You have the right to request that we restrict how your protected health information about you is used or disclosed 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 disclosure of protected health information about you for treatment, payment, health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance to your prior consent.

_____ _____

Signature Date

_____

Print Name

Office use only

- ☐ Patient accepted Notice of Privacy Practices information.
- ☐ Patient **declined** Notice of Privacy Practices information.

Initial: _____