Privacy Practice Acknowledgment

I understand that as part of my healthcare, Specialists in Gastroenterology originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health 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 payer can verify that services billed were actually provided
- a tool for routine healthcare operations such as assessing quality and reviewing the competence healthcare professionals

I have been provided with a *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and will provide current copy to me at any time upon my request. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent at any time by providing notice to Specialists in Gastroenterology, in writing, except to the extent that the organization has already taken action in reliance thereon. I understand my refusal to sign a consent or my request for restrictions will not affect my treatment however I may be personally responsible for payment of the services I receive.

Unless I direct them not to, I understand that Specialists in Gastroenterology will contact me by telephone or e-mail and (1) will identify themselves as representing Specialists in Gastroenterology, (2) will confirm my office appointments, (3) may discuss changes in my medications and (4) may discuss my test results. <u>I understand they may leave these messages on my answering machine if I am unavailable. I understand they will give these messages to anyone answering my home telephone.</u> They may also notify me by contacting: (name, relationship and telephone number)

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I request the following restrictions to the use or disclosure of my health information:

__Do not leave any messages with the individuals answering my home telephone
__Do not leave any messages on my answering machine

___You may leave messages on my answering machine but:
__Do not identify "Specialists in Gastroenterology" in the message
__Do not confirm my office appointments
__Do not discuss changes in my medications in the message
__Do not leave test results in the message

__Other (please specify)

This authorization will remain valid unless changed by me in writing to Specialists in Gastroenterology.

Signature_____________________________________ Date_________________________________
Patient or legal representative

Printed Name_________________________________ Date of Birth_________________________