TEXARKANA GASTROENTEROLOGY CONSULTANTS

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

PRIVACY PRACTICE NOTIFICATION

I, _____, understand that as part of my health care, Texarkana Gastroenterology Consultants, originates and maintains paper and/or electronic 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 & 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, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I hereby consent to the clinics use and disclosure of my individually identifiable health information for the purposes listed above and other purposes relating to my treatment, the payment of my health care, and other health care operations of the clinic. In addition, I acknowledge that I received, on the date indicated below, a copy of the clinics Notice of Privacy Practices, which describes the obligations of the clinic regarding its use and disclosure of my individually identifiable health information and my rights regarding this information. I also understand that the clinic reserves the right to change its notice and practices. If the clinic changes the notice, I can obtain a revised copy by asking the Administrator of the clinic. 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 other healthcare operations and that the clinic is not required to agree to the restrictions requested. If the clinic does agree to such restrictions, however, the clinic must comply with such restrictions.

Texarkana Gastroenterology Consultants is authorized by this form to disclose or discuss my protected health information with the following named people:

Name(s) & Relationship(s)

_____ ☐ Medical Information ☐ Appt./Testing

_____ ☐ Medical Information ☐ Appt./Testing

_____ ☐ Medical Information ☐ Appt./Testing

I understand that I have the right to revoke anyone listed on the authorization and I must fill out the form before the revocation can be completed. All revocations must be sent to the clinic address to the attention of the ***Privacy Officer***, and are not effective until received by such.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize the release of medical information in the possession of TEXARKANA GASTROENTEROLOGY CONSULTANTS, PA, concerning my illness, treatment, or recommendations to insurance companies, or medical facilities, requesting such information.
I understand my medical record MAY contain copies of information received from other healthcare facilities or doctors, and I authorize the release of this information.
I further understand my medical records MAY contain reference to, or results of, HIV antibody (AIDS) testing, testing for communicable diseases, and treatment of drug or alcohol use, or abuse, and I authorize the release of this information.

PATIENT'S PRINTED NAME DATE

PATIENT'S SIGNATURE

WITNESS