ADVANCED GASTROENTEROLOGY OF SOUTH FLORIDA, PA

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NEW PATIENT CONSENT TO USE DISCLOSURE OF HEALTH INFORMATION TREATMENT, PAYMENT OR HEALTHCARE OPERATION

I _____, understand that as part of my healthcare, Advanced Gastroenterology of South Florida, PA originates and maintains paper and electronic records describing my health history, symptoms, examinations, test results, diagnosis, 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 toll for routine healthcare operations such as assessing quality and renewing the competence of healthcare professionals.

I understand and I have been provided with a *Notice of Information Practices* that provides a more detailed description of information uses and disclosures. I understand that I have the following rights and privileges.

- The right to review the notice prior to signing this consent.
- The right to object to use of my health information for directory purposes.
- The right to request restrictions as to how my health information may be disclosed to carry out treatment, payment or health care operations.

I understand that Advanced Gastroenterology of South Florida, PA's care is not required to agree to the restrictions requested. I also understand that I may revoke this consent in writing, except to the extent that the organization has already taken action. Further, I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of Code Federal Regulations.

Advanced Gastroenterology of South Florida, PA reserves the right to change their notice and practices in accordance with Section 164.520 of the Code if Federal Regulation.

I understand that as part of Advanced Gastroenterology of South Florida, PA's treatment, payment or health care operations, it may become necessary to disclose my protected health information to another entity and, I consent to such disclosures for these permitted uses, including disclosure via fax.

I fully understand and □ accept or □ decline the term of this.

Patient Signature _____ Date _____

FOR OFFICE USE ONLY

__ Consent Reviewed by _____ Date _____

__ Consent refused by patient and treatment refused as permitted.

__ Consent added to the patient's medical record on _____