

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

Acknowledgement of Receipt of Privacy Notice

I understand that as part of my healthcare, Consultants in Gastroenterology, South Carolina Endoscopy Center and South Carolina Endoscopy Center- Northeast, 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 and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of information uses and disclosure. 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. I understand that I have the right to request restrictions 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 in writing, except to the extent that the organization has already taken action in reliance thereon.

I request the following restrictions to the use or disclosure of my health information (specify agency, healthcare provider, etc. that will be restricted information, expiration of the request, type of information, reason for restriction, etc.).

Signature of Patient or Legal Representative _____

Witness _____

Date _____