Notice of Privacy Practices and Patient Consent for Use and Disclosure of Protected Health Information

Revised October 5, 2013

I understand the Health Insurance Portability and Accountability Act of 1994 (HIPAA), I have certain patient rights regarding my protected health information.

I understand that **Summit Gastroenterology** may use or disclose my protected health information treatment, payment or health care operations – which means for providing health care to me, the patient; handling billing and payment; and, taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

Summit Gastroenterology has a detailed document called the *Notice of Privacy Practices.* It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

I understand that I have the right to read the *Notice* before signing this agreement. If I ask, **Summit Gastroenterology** will provide me with the most current *Notice of Privacy Practices.*

My signature below indicates that I have been given the chance to review such copy of the *Notice of Privacy Practices.* My signature means that I agree to allow **Summit Gastroenterology** to use and disclose my protected health information to carry out treatment, payment, and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that **Summit Gastroenterology** has taken action relying on this consent.

_____ _____

Signature (*Patient or Legal Custodian/Authorized Representative)* Date

_____

Patient Name

_____ _____

Relationship to Patient (*If signed by another party)* Date

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our notice at any time contact Summit Gastroenterology at (816)554-3838.

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