New Patient Consent to the Use and Disclosure of Health Information
for Treatment, Payment , or Healthcare Operations

*I understand that as p*art of my health care, Metro Atlanta Gastroenterology and Metro Atlanta Endoscopy 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 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 my insurance carrier 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 Policies that provides a more complete 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 the use of my health information for directory purposes, and
. The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I further understand that Metro Atlanta Gastroenterology and/or Metro Atlanta Endoscopy reserve the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the code of Federal Regulations. Should the practice or endoscopy center change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email)

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

_____

_____

_____

I understand that Metro Atlanta Gastroenterology and/or Metro Atlanta Endoscopy Center 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 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 the Code of Federal Regulations.

I understand that as part of this organization'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 disclosure for these permitted uses, including disclosures via fax.
I fully understand and accept/decline the terms of this consent.

_____ _____

Patient's Signature Date

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HIPAA RELEASE OF MEDICAL RECORDS
TO DESIGNATED INDIVIDUALS

I hereby authorize one or all of the designated parties listed below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to the treatment and payment. I understand that the identity of designated parties must be verified before the release of any information. **Do not include physicians,or insurance companies, only family/friends.**

Authorized Designees:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

_____
Patient Name

_____
Patient Signature

_____
Date

**When leaving a message pertaining to your medical records, what is the best number with which to contact you.
_____**

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