

THE CENTER FOR COLON AND DIGESTIVE DISEASE, P.C.

119 Longwood Drive Huntsville, AL 35801 (256) 533-6488
333Whitesburg Drive Huntsville, AL 35801 (256) 519-4437
460 Lanier Road Madison, AL 35758 (256) 519-2800

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

1. THIS IS TO INFORM YOU THAT THE HUNTSVILLE ENDOSCOPY CENTER MAY USE AND DISCLOSE YOUR HEALTH INFORMATION THAT IDENTIFIES YOU, AND THAT CONSISTS OF YOUR PAST, PRESENT, OR FUTURE PHYSICAL OR MENTAL HEALTH OR CONDITION. THE PROVISION OF YOUR HEALTHCARE; AND THE PAST, PRESENT OR FUTURE PAYMENT FOR THE PROVISION OF YOUR HEALTHCARE (THIS HEALTH INFORMATION IS REFERRED TO HEREIN AS "PROTECTED HEALTH INFORMATION").
2. THE USE AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION WILL BE TO CARRY OUT TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS FOR THE COLON AND DIGESTIVE DISEASE CENTER.
3. YOU HAVE THE RIGHT TO REQUEST THAT THE COLON AND DIGESTIVE DISEASE CENTER BE RESTRICTED FROM USING OR DISCLOSING YOUR PROTECTED HEALTH INFORMATION IN CARRYING OUT TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS; HOWEVER, THE COLON AND DIGESTIVE DISEASE CENTER IS NOT REQUIRED TO AGREE TO YOUR REQUESTED RESTRICTIONS, THEN IT WILL COMPLY WITH YOUR REQUEST.
4. YOU HAVE THE RIGHT TO REVOKE THIS CONSENT. THIS REVOCATION MUST BE MADE IN WRITING TO THE COLON AND DIGESTIVE DISEASE CENTER. THIS REVOCATION WILL BE VALID EXCEPT TO THE EXTENT THAT THE COLON AND DIGESTIVE DISEASE CENTER HAS TAKEN ACTION IN RELIANCE ON THIS CONSENT.

FURTHER, I HERBY AUTHORIZE AND GIVE MY CONSENT TO THE HUNTSVILLE ENDOSCOPY CENTER TO COMMUNICATE ANY OF MY PROTECTED HEALTH INFORMATION TO THE FOLLOWING PERSONS:

<u>NAME</u>	<u>RELATIONSHIP</u>
_____	_____
_____	_____
_____	_____

_____ I ACNOWLEDGE RECEIPT OF THE NOTICE OF PRIVACY PRACTICES FORM WHICH DETAILS HOW PROTECTED HEALTH INFORMATION MAY BE USED AND DISCLOSED, AND HOW I MAY ACCESS THAT INFORMATION.

PATIENT NAME (PLEASE PRINT)

SIGNATURE (PATIENT)

SIGNATURE (AUTHORIZED REPRESENTATIVE)

DATE

DATE OF BIRTH

SS#