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### **Consent for Purposes of Treatment, Payment, and Health Care Operations**

I consent to the use or disclosure of my protected health information by GI Consultants for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of GI Consultants.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. GI Consultants is not required to agree to the restrictions that I may request. However, if GI Consultants agrees to a restriction that I request, the restriction is binding on GI Consultants. I have the right to revoke this consent, in writing, at any time, except to the extent that GI Consultants has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identified me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review GI Consultants Inc.'s Notice of Privacy Practices prior to signing this document.

The Notice of Privacy Practices describes the type of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of GI Consultants. The Notice of Privacy Practices for GI Consultants Inc. is also provided in the lobby. This Notice of Privacy Practices also describes my rights and the duties of GI Consultants with respect to my protected health information.

GI Consultants reserves the right to change the privacy practices that are described in the Notice of Privacy Practices.

I may obtain a revised notice of privacy practices by contacting the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

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**Signature of Patient or Personal Representative**

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Patient or Personal Representative