

PALM BEACH GASTROENTEROLOGY CONSULTANTS, LLC

**PATIENT CONSENT FOR USE AND DISCLOSURE OF
PROTECTED HEALTH INFORMATION**

I hereby give my permission for **PALM BEACH GASTROENTEROLOGY CONSULTANTS, LLC** to use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). (**PALM BEACH GASTROENTEROLOGY CONSULTANTS, LLC's**) notice of privacy practices provides a more complete description of such uses and disclosures.)

I have the right to review the notice of Privacy Practices prior to signing this consent. The physicians of **PALM BEACH GASTROENTEROLOGY CONSULTANTS, LLC** reserve the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **PALM BEACH GASTROENTEROLOGY CONSULTANTS, LLC, 1157 SOUTH STATE ROAD 7, WELLINGTON, FL 33414**

With this consent **PALM BEACH GASTROENTEROLOGY CONSULTANTS, LLC**, may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any calls pertaining to my clinical care including laboratory results among others.

With this consent **PALM BEACH GASTROENTEROLOGY CONSULTANTS, LLC** may mail to my home or alternative locations any item that assists the practice in carrying out TPO such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With this consent **PALM BEACH GASTROENTEROLOGY CONSULTANTS, LLC** may e-mail to my home or alternative locations any item that assists the practice in carrying out TPO such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

PALM BEACH GASTROENTEROLOGY CONSULTANTS, LLC

**PATIENT AUTHORIZATION FOR PRACTICE TO RELEASE
PROTECTED HEALTH INFORMATION TO THIRD PARTIES**

By signing this authorization, I authorize **PALM BEACH GASTROENTEROLOGY CONSULTANTS, LLC** to use and/or disclose certain protected health information (PHI) about me for the third party listed below

This authorization permits **PALM BEACH GASTROENTEROLOGY CONSULTANTS, LLC** to use or disclose to

Entity to Receive the Information

The following individually identifiable health information (specific describe the information to be released, such as date(s) of service, level of detail to be released, origin of information, ect.)

This authorization will expire on _____
(Expiration Date or Defined Event)

When my information is used or disclosed pursuant to this authorization, it may be subject to disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy rule. I have the right to revoke this authorization in writing except to the extent that **PALM BEACH GASTROENTEROLOGY CONSULTANTS, LLC** has acted in reliance upon this authorization. My written revocation must be submitted to **PALM BEACH GASTROENTEROLOGY CONSULTANTS, LLC., 1157 SOUTH STATE ROAD 7, WELLINGTON, FL 33414**

Signed by: _____
Signature of Patient or Legal Guardian Relationship to Patient

Patient's Name Date

Print Name of Patient or Legal Guardian

By signing this form, I am consenting to **PALM BEACH GASTROENTEROLOGY CONSULTANTS, LLC**'s use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosure in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **PALM BEACH GASTROENTEROLOGY CONSULTANTS, LLC** may decline to provide treatment for me.

Signature of Patient or Legal Guardian

Relationship to Patient

Patient's Name

Date

Print Name of Patient or Legal Guardian