Austin Gastroenterology
www.austingastro.com

General Consent to Use and Disclosure of Protected Health Information

Name:_____ Account Number: _____

Age: _____ Date of Birth: _____

I, _____ , understand that ***Austin Gastroenterology, PA*** creates and maintains medical and related records that include personal healthcare information, including my health records, symptoms, demographic information, diagnoses, examination and test results, treatment, and any plans for future care or treatment. This is my "protected health information".

I understand and consent to the use and disclosure of my Health Information by ***Austin Gastroenterology, PA*** for the following purposes:

- My treatment: This includes the provision, coordination, or supervision of my healthcare and related services, including the coordination or management of my care and consultation between healthcare professionals related to my treatment, or my referral to another healthcare professional.
- Payment for healthcare services provided to me: This includes actions undertaken by a health plan to decide coverage or the provision of benefits to me, by my Provider or a health plan to obtain or provide compensation for my care, or otherwise related to me.
- My Provider's internal operations: This includes quality assessment and improvement activities; reviewing provider performance and training; activities relating to health insurance and benefits; conducting or arranging for medical review, legal services, and audits; business planning and development; and business management and general administrative activities including customer service, resolution of internal grievances, due diligence, and creating de-identified healthcare information.

I understand and agree that:

- I have the right to review ***Austin Gastroenterology, PA's*** *Notice of Privacy Practices for Protected Health Information*, which provides a much more detailed description of information uses and disclosures, prior to signing this Consent.
- ***Austin Gastroenterology, PA*** may change or modify its *Notice of Privacy Practices for Protected Health Information* at any time and I have the right to obtain a revised Notice of Privacy Practices by accessing **www.austingastro.com** website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.
- I have the right to request restrictions as to how my Health Information may be used or disclosed to carry out treatment, payment, or healthcare operations. I understand and agree that my Provider is not required to agree to any restrictions that I may request, but if my Provider agrees, it will be bound by that restriction.
- I have the right to revoke this Consent by notifying my Provider ***in writing*** that I revoke this Consent unless my Provider has used or disclosed my Health Information in reliance on this Consent.
- **YOU MAY DISCLOSE MY HEALTHCARE INFORMATION TO THE FOLLOWING INDIVIDUALS OR ENTITIES (PLEASE PRINT):**

First and Last Name	Relationship to Patient	Phone Number

_____ _____

Signature of Patient or Legal Representative *Date*

_____ _____

Austin Gastro Representative *Date*