Atlantic Coast Gastroenterology, Associates, LLC

A division of Allied Digestive Health

Consent for Use and Disclosure of Private Health Information (PHI)

Use and Disclosure of your Protected Health Information
Your PHI will be used by Atlantic Coast Gastroenterology, or disclosed to others, for the purpose of treatment, obtaining payment, or supporting the day to day healthcare operations of the practice.

Notice of Privacy Practices
You should review our Notice of Privacy Practices for more complete description of how your health information may be used or disclosed. A copy of this notice will be given to you upon your request.

Requesting a Restriction on the Use or Disclosure of Your Information
You may request a restriction on the use or disclosure of your protected health information. Atlantic Coast Gastroenterology may agree or not agree to restrict the use and disclosure of your protected health information. If Atlantic Coast Gastroenterology agrees to your request, the restriction will be binding on the practice as a whole. Unauthorized use and disclosure of protected health information is a violation of an agreed upon restriction, and will be a violation of federal privacy standards.

I give my consent to be contacted in the following manner:

	Home	Work	Cell
It is okay to contact me at:	Y / N	Y / N	Y / N
It is okay to leave a call back number at:	Y / N	Y / N	Y / N
It is okay to leave a detailed message at:	Y / N	Y / N	Y / N

Please list people we may speak to other than you, and their relationship with you:

Revocation of Consent
You may revoke this consent in the use and disclosure or your Protected Health Information at any time. You must revoke this consent in writing. Any use and disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change Privacy Practices
Atlantic Coast Gastroenterology reserves the right to modify the privacy practices outline in the notice.

Signature
I have reviewed this consent form and hereby give my permission to Atlantic Coast Gastroenterology to use and disclose my PHI in accordance with these guidelines.

Patient Name: _____ Date: _____

_____
Signature of Patient or Patient Representative