Allied Digestive Health

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

Use and Disclosure of PHI

Your PHI will be used by Allied Digestive Health, or disclosed to other authorized third parties, for the purpose of treatment, obtaining payment, or supporting the day-to-day healthcare operations of the practice.

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. Allied Digestive Health may agree to restrict the use or disclosure of your protected health information. If ADH agrees to your request, the restrictionwill be binding on practice as a whole. Unauthorized use and disclosure of PHI is a violation of an agreed upon restriction and will be a violation of federal privacy standards.

I give consent to be contacted in the following manner:

Primary Phone: _____

- ☐ Do not call this number
- ☐ Ok to leave message to **call back only**
- ☐ Ok to leave message **with results and detailed information, including billing**

Secondary Phone: _____

- ☐ Do not call this number
- ☐ Ok to leave message to **call back only**
- ☐ Ok to leave message **with results and detailed information, including billing**

Other persons authorized to receive my health information:

Name:_____Relationship:_____Phone:_____

Name:_____Relationship:_____Phone: _____

Revocation of Consent

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

I have reviewed this consent form and hereby give my permission to Allied Digestive Health to use and disclose myProtected Health Information in accordance with these guidelines.

_____ _____

Signature of Patient or Guardian Date

_____

Printed Name of Patient or Guardian