Digestive Health Specialists, P.A.
Colon Cancer Prevention Center
336.768.6211 336.768.6869 Fax
www.digestivehealth.ws

Consent for Purposes of Treatment, Payment and Health Care Operations

I voluntarily consent to the healthcare treatment ("Treatment") from the physicians and staff at **Digestive Health Specialists, P.A**. **(DHS)**. I consent to any necessary Laboratory Testing performed at DHS. I am aware that the practice of medicine is not an exact science and no guarantees have been made to me regarding the result of treatments or examinations by my caregivers. I consent to the use or disclosure of my protected health information by DHS for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, or to conduct health care operations of DHS. I understand that any diagnosis or treatment of me by my attending physician may be conditioned upon my consent as evidenced by my signature on this document.

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. DHS is not required to agree to the restrictions that I may request. However, if DHS agrees to a restriction that I request, the restriction is binding on DHS and my attending physician.

I have the right to revoke this consent, in writing, at any time, except to the extent that my attending physician or DHS 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 identifies me, or there is a reasonable basis to believe the information may identify me.

Notice of Privacy Practices

The Notice of Privacy Practices describes the types 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 **Digestive Health Specialists, P.A**. The Notice of Privacy Practices also describes my rights and the duties of my attending physician with respect to my protected health information.
An individual copy of the DHS Notice of Privacy Practices is available to anyone that requests a copy. DHS has also posted the Notice of Privacy Practices in each DHS reception room and on the DHS website at www.digestivehealth.ws.

Digestive Health Specialists, P.A. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. If the notice is changed, I may obtain a revised notice of privacy practices by accessing the **DHS** web site, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment. The DHS Notice of Privacy Practice has been provided to me and I have been provided the opportunity to review the notice prior to signing this document.

_____ _____
Print Name Date

_____
Signature of Patient or Personal Representative

SAMPLE