

- ◆ The right to review the notice prior to signing this consent,
- ◆ The right to object to the use of my health information for research or marketing purposes, and
- ◆ 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 that Waco Gastroenterology Associates is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Waco Gastroenterology Associates reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Waco Gastroenterology Associates change their notice, they will send a copy of any revised notice to the address I have provided, (whether U.S. Mail or, if I agree, e-mail).

I wish to have the following restrictions to the use or disclosure of my health information: _____

I understand that as part of this organization’s treatment, payment or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax. I fully understand and accept the terms of this consent.

I UNDERSTAND THAT WACO GASTROENTEROLOGY ASSOCIATES WILL FILE MY INSURANCE, BUT I AM RESPONSIBLE FOR PAYMENT OF MY ACCOUNT. I AGREE THAT I AM RESPONSIBLE FOR COMPLYING WITH MY INSURANCE COMPANY’S RULES AND FOR PAYMENT OF ANY BALANCE NOT COVERED BY INSURANCE.

I HEREBY AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY FOR THE PROCESSING OF INSURANCE AND ASSIGN ALL MEDICAL AND / OR SURGICAL BENEFITS TO INCLUDE MAJOR MEDICAL BENEFITS TO WHICH I AM ENTITLED TO WACO GASTROENTEROLOGY ASSOCIATES. THIS ASSIGNMENT WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING. A PHOTOCOPY OF THIS ASSIGNMENT IS TO BE CONSIDERED AS VALID AS AN ORIGINAL.

 Patient or Guardian

 Date

FOR OFFICE USE ONLY

_____ Consent received by _____ on _____.

_____ Consent refused by patient, and treatment refused as permitted.

_____ Consent added to the patient’s medical record on _____.