

# Colon Rectal Health Center

## Consent to the Use and Disclosure of Health Information For Treatment, Payment or Healthcare Operations

I understand that as part of my healthcare, Colon Rectal Health Center originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care and treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I have been provided with a *Notice of Privacy Practices* dated April 1, 2003 that provides a more complete description of information uses and disclosures. I understand that I have a right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and will provide current copy to me at any time upon my request. I understand that 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 and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent at any time by providing notice to Colon Rectal Health Center in writing except to the extent that the organization has already taken action in reliance thereon. I understand my refusal to sign a consent or my request for restrictions will not affect my treatment however I may be personally responsible for payment of the services I receive.

I understand Colon Rectal Health Center staff, unless I direct them not to, will contact me by telephone and (1) will identify themselves as representing Colon Rectal Health Center, (2) will confirm my office appointments, (3) may discuss changes in my medications and (4) may discuss my test results. I understand they may leave these messages on my answering machine if I am unavailable. I understand they will give these messages to anyone answering my home telephone. They may also notify me by contacting: (name and telephone number)

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### I request the following restrictions to the use or disclosure of my health information:

- Do not leave any messages with the individual answering my home telephone
- Do not leave any messages on my answering machine

You may leave messages on my answering machine but:

- Do not identify "Colon Rectal Health Center" in the message
- Do not confirm my office appointments
- Do not discuss changes in my medications in the message
- Do not leave test results in the message

Other (please specify)

This authorization will remain valid unless changed by me in writing to Colon Rectal Health Center.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Patient or legal representative