

Notice of Privacy Practices and Patient Consent For Use and Disclosure of Protected Health Information

PATIENT NAME

DATE

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected health information.

I understand that Bux-Mont Gastroenterology may use or disclose my protected health information for treatment, payment or health care operations—which means for providing health care to me, the patient; handling billing and payment; and, taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

Bux-Mont Gastroenterology has a detailed document called the '**Notice of Privacy Practices**'. It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

I understand that I have the right to read the '**Notice**' before signing this agreement. If I ask, Bux-Mont Gastroenterology will provide me with the most current *Notice of Privacy Practices*.

My signature below indicates that I have been given the chance to review such copy of the *Notice of Privacy Practices*. My signature means that I agree to allow Bux-Mont Gastroenterology to use and disclose my protected health information to carry out treatment, payment, and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that Bux-Mont Gastroenterology has taken action relying on this consent.

SIGNATURE (Patient or Legal Custodian/Authorized Representative)

DATE

Relationship to Patient if signed by another party

DATE

You may obtain a copy of our *Notice of Privacy Practices*, including any revisions of our '**Notice**' at any time by contacting: Bux-Mont Gastroenterology Associates 1107 Bethlehem Pike Sellersville, PA 18960.

FORM Us