Endoscopic Services, P.A.
1431 S. Bluffview, Suite 215
Wichita, KS 67218

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

NAME: ____CHART #:______________

SECTION B: TO THE PATIENT - PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

PURPOSE OF CONSENT: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

NOTICE OF PRIVACY PRACTICES: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our practices and to make new provisions effective for all protected health information we maintain. We will post the current Notice at our office with the effective date. You may obtain a copy of our Notice of Privacy Practices, including any revisions by contacting us.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE: I have been presented with a copy of this practice's ***Notice of Privacy Practices*** detailing how my information may be used and disclosed as permitted under federal law. I understand the contents of the Notice.

PERMISSION TO DISCLOSE INFORMATION TO THOSE INVOLVED IN MY CARE: I hereby authorize Endoscopic Services, P.A. to disclose the following Protected Health Information (PLEASE INDICATE BY CHECK MARK):

______Appointment times and dates
______Procedure / lab results
______ALL health information
_______Discharge instructions
_______Billing and Accounts Receivable

To the following people because they are involved with my health care: (PLEASE LIST NAME(s) ON THE LINE PROVIDED)

Spouse:________________________
Friend:________________________
Child(ren):__________________________
Other:______________________________

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

PATIENT SIGNATURE: ____**DATE:**______________

If this Consent is signed by a personal representative on behalf of the patient, complete the following:
PERSONAL REPRESENTATIVE's NAME: ____
RELATIONSHIP TO PATIENT:____

RIGHT TO REVOKE: You have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Privacy Officer, Endoscopic Services, P.A. Please understand that revocation of this Consent will NOT affect any action we took in reliance to this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

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

Date: __________ Time: ___________ Employee Name: ____