Digestive Health Partners – Hendersonville
Carolina Mountain Gastroenterology
Endoscopy Center

Welcome to our Practice

This disclosure pertains to HIPAA – The Health Insurance Portability and Accountability Act. HIPAA calls for, among other things, security standards protecting the confidentiality and integrity of "individually identifiable health information," past, present, and future.

Your medical records will be kept confidential and only you the patient will have access to them, except in certain circumstance, for example for billing purposes, your insurance company may request your records in order to clear a claim. When you signed with your insurance company, you have already signed for the release of relevant records, if necessary. Also, when you need authorization from your insurance company to see a specialist, your insurance company may request a copy of your records. In order to continue your care through a specialist, we may fax, mail, or give verbal knowledge of your medical history to the specialist.

HIPAA Standards prohibit us from leaving results of your lab-tests, x-rays, diagnostics, medications, etc. related to your specific health condition on your voice mail, answering machine, fax, etc. without your authorization. If you feel that your message retrieval system is safe and your information is protected, you must give us your written consent to leave your information on your messaging systems. **Please choose one** of the options below. Note: If you would like to revoke your option at any time, we will need your written notification.

☐ **YES**, I give my permission to leave my health-related information or appointment reminders on my answering system, voice mail, fax, etc.

☐ **NO**, do not leave my health-related information or appointment reminders on my answering system, voice mail, fax, etc.

HIPAA standards prohibit us from discussing your medical history with anyone, other than yourself, without your consent. Note: If you decide to revoke your permission at any time, we will need your written notification.

Yes, you have my permission to discuss any medical matters pertaining to my health with:

_____ (Print Name of Person)

Relationship: _____ (Spouse/ Son / daughter, etc)

I have read and agree with all the above information.

Print Name_____ DOB: _____

Signature: _____ Date:_____