ASHEVILLE GASTROENTEROLOGY ASSOCIATES

A Division of Digestive Health Partners, P.A.

CONSENT TO RELEASE PERSONAL HEALTH INFORMATION (PHI)

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our notice **before** signing this consent and prior to any service being provided to you by the Practice. The Practice reserves the right to change the Notice of Privacy policies. If we change our notice, you may obtain a revised copy by sending a letter to the Practice's HIPAA Officer or by asking the provider's receptionist. You can also obtain a copy on the clinic's website at www.ashevillegastro.com.

By signing this form, you acknowledge that you have been given an opportunity to read the clinic's Notice of Privacy Practices prior to any service being provided to you by this Practice, and you consent to the use and disclosure of your medical information to other healthcare providers involved in your care and for treatment, payment and healthcare operations. You have the right to revoke this consent in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act (HIPAA) and Health Information Technology for Economic and Clinical Health (HITECH).

I authorize Physicians/staff of DIGESTIVE HEALTH PARTNERS to release information pertaining to my condition and/or care to those individuals listed below:

Name	DOB	Relationship	Contact Phone Number

DIGESTIVE HEALTH PARTNERS physicians/staff may contact me in the following manner:
(Check all that apply)

Preferred Method of Contact (please check):

☐ **Home Telephone:** ____________________
  ☐ OK to leave message on machine with detailed message

☐ **Cell Number:** ____________________
  ☐ OK to leave message on voicemail with detailed message

☐ **Work Telephone:** ____________________

☐ **Patient Portal E-Mail:** ____________________

______________________________ Date: ____________________
Signature of Patient/Legal Representative

If Legal Representative, relationship to Patient ______________________________

WE CANNOT SPEAK TO ANYONE YOU HAVE NOT LISTED ABOVE.
THIS FORM MUST BE COMPLETED AND SIGNED.