Carolina Mountain Gastroenterology
And 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 circumstances, 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 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.

Please sign and date here if you agree with all of the above. If you have questions, please speak with one of our representatives.

Signature: _____ **Date:** _____

By HIPAA Standards, we are not allowed to leave results of your lab-tests, x-rays, diagnostics, medications, etc. related to your specific health condition on your voice mail, answering machine, fax, etc. However if you feel that your message retrieval system is safe and your information is protected, you must give us your written consent to allow us 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 on my answering system, voice mail, fax, etc.**

☐ **No, do not leave health related information on my answering machine, voice mail or fax.**

Signature: _____ **Date:** _____

By HIPAA standards, we are not allowed to discuss your medical problems with your spouse or significant other. Please indicate if you would like us to speak with your spouse/significant other if and when the need arises. 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 matter pertaining to my health with _____ (name of person)

Relationship: _____ (spouse/son/daughter, etc.)

Signature: _____ **Date:** _____

Yes, you have my permission to leave reminders of appointment dates and times on my home/cell numbers provided by me.

Signature: _____ **Date:** _____