AGIS Alexandria GastroIntestinal Specialists

General Consent to Use and Disclosure of Protected Health Information

Name: _____

Account #:_____ Date of Birth: _____

I, _____, understand that **Alexandria GastroIntestinal Specialists** create and maintain medical records that include personal healthcare information, including my health records, symptoms, demographic information, diagnoses, examination, and test results, treatment, and any plans for future care of treatment. This is my "protected health information".
I understand and consent to the use and disclosure of my Health Information by **Alexandria GastroIntestinal Specialists** for the following purposes:

- **MY TREATMENT**- This includes the provision, coordination, or supervision of my healthcare, including the coordination or management of my care and consultation between healthcare professionals related to my treatment or my referral to another healthcare professional.
- **PAYMENT FOR HEATHCARE SERVICES PROVIDED TO ME**: This includes actions undertaken by a health plan to decide coverage or the provision of benefits to me, by my provider or a health plan to obtain or provide compensation for my care.
- **MY PROVIDER'S INTERNAL OPERATIONS**: This includes quality assessment and improvement activities; reviewing provider performance and training; activities relating to health insurance and benefits; conducting or arranging for medical review, legal services, and audits; business planning and development; and business management and general administrative activities.

I understand and agree that:

- I have the right to review **Alexandria GastroIntestinal Specialists'** *Notice of Privacy Practices*, which provides a detailed description of information uses and disclosures, prior to signing this consent.
- **Alexandria GastroIntestinal Specialists** may change of modify its *Notice of Privacy Practices* at any time and I have the right to obtain a revised copy by calling the office and requesting a copy be sent in the mail or asking for one at the time of my next appointment.
- I have the right to request restrictions as to how my Health Information may be used or disclosed to carry out treatment, payment, or healthcare operations. I understand and agree that my provider is not required to agree to any restrictions that I may request, but if my provider agrees, it will be bound by that restriction.
- Providers at AGIS may require, in the course of my treatment, that I have lab work, radiology, procedures, etc. that will be performed by offices other than AGIS and that they will send me statements from their offices and that AGIS is in no way responsible for their billing practices.

I authorize AGIS to release my medical, including prescriptions, x-rays, orders, doctor excuse, etc. and billing information to the following individuals or entities. This is not a records release, only information requested.

First and Last Name	Relationship to Patient	Phone Number

_____ _____

Signature of Patient or Legal Representative **Date**

_____ _____

Signature of AGIS Representative **Date**