Patient Acknowledgement and Understanding of Dr. Saracino, Gastroenterology PC's Privacy Practice

Patient's name: _____ Chart#_____

Date of birth: _____SSN: _____

I understand that the patient's health information is private and confidential. I understand that Dr. Saracino, Gastroenterology, PC works very hard to protect the patient's privacy and preserve the confidentiality of the patient's personal health information.

Under the terms of this consent, I can ask Dr. Saracino, Gastroenterology, PC to limit how the patient's personal health information is used or disclosed to carry out treatment, payment or health care operations. I understand that Dr. Saracino, Gastroenterology, PC does not have to agree to my request. If Dr. Saracino, Gastroenterology, PC does agree to my request, I understand that would follow the agreed limits as outlined in the Privacy Policy.

I may cancel this consent in writing at any time by doing one of the following:

1. Signing and dating a form that Dr. Saracino, Gastroenterology, PC can give me called "Revocation of Consent for Use and Disclosure of Health Care Information"; or

2. Writing, signing, and dating a letter to Dr. Saracino, Gastroenterology, PC. If I write a letter, it must say that I want to revoke my consent to authorize the use and disclosure of the patient's personal health information for treatment, payment, and health care operations.

If I revoke this consent, Dr. Saracino, Gastroenterology, PC does not have to provide any further health care services to the patient.

My signature below indicates that I have been given the chance to review a current copy of Dr. Saracino, Gastroenterology, PC's "Notice of Privacy Practices". My signatures means that I agree to allow Dr. Saracino, Gastroenterology, PC to use and disclose the patient's personal health information to carry out treatment, payment, and health care operations.

X_____ _____ _____
Patient or legally authorized individual signature Date Time

_____
Relationship to patient if signed by anyone other than the patient (parent, legal guardian, etc.)

_____ _____
Refusal to sign (signed by staff with reason) Date

I request that health plan benefits be made on my behalf to Dr. Saracino, Gastroenterology, PC for any services furnished to me. I authorize Dr. Saracino, Gastroenterology, PC to release to the respective health plans and its agents any information needed to determine these benefits payable for related services.

I understand that I remain financially responsible to Dr. Saracino, Gastroenterology, PC for any and all charges not covered by insurance. Patients of contracted payers may be responsible for payment as directed by the insurance company, as the patient's responsibility.

X_____ _____
Patient or legally authorized individual signature Date