Gastrointestinal Medicine Associates, P.C.

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HIPAA – Notice of Privacy Practices

I, the patient, hereby give consent to Gastrointestinal Medicine Associates, P.C. (GMA) to use or disclose, for the purpose of carrying out treatment, payment, or health care operations, all information contained in my patient record.

I, the patient, acknowledge the review and / or receipt of the physician's Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information. I understand that the physician has reserved a right to change his or privacy practices that are described in the Notice. I also understand that a copy of a revised Notice will be available to me upon a written request to the Privacy Officer.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to the physician. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the physician's office.

I understand that I have the right to request that the practice restricts how my individual identifiable health information is used and / or disclosed to carry out treatment, payment or health operations. I understand the practice does not have to agree to such restrictions, but that once such restrictions are agreed to, the practice and their agents must adhere to such restrictions.