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ACKNOWLEDGMENT AND CONSENT

I understand that Colorectal Health Northwest, LLC (referred to as "This Practice") will use and disclose **health information** about me.

I understand that my **health information** may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnosis, treatments, procedures, prescriptions, and similar types of health related information.

I understand and agree that This Practice may **use and disclose** my health information in order to:

- Make decisions about and plan for my care and treatment;
- Refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- Determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- Perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how This Practice will handle health information about me. This written description known as a **Notice of Privacy Practices** and describes the uses and disclosures of health information made and the information practices followed by employees, staff and other office personnel of This Practice, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be reviewed from time to time and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or summary of the most current version of This Practice's Notice of Privacy Practices in effect will be available in the reception area.

I understand that I have the right to ask that some or all of my information not be used or disclosed in the manner described in the Notice of Privacy Practices, and understand that This Practice is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that I can receive a copy of the Notice of Privacy Practices if I request one.

Patient Signature: ____________________ Date of Birth: ______________ Date: ______________

-OR-

Patient Representative Signature: ______________________________ Date: ____________________

Description of Representative's Authority:

CONSENT TO DISCUSS PROTECTED HEALTH INFORMATION

If you are unavailable, may we leave detailed medical information such as normal lab results or normal biopsy reports on your voicemail or with someone at your residence?

☐ **YES—you may leave information as above** ☐ **NO—you may not leave any information with anyone**

If yes, please list name, relationship and phone number of person(s) we are authorized to discuss your medical care and/or account with:

Name: ____________________________ Relationship: ____________ Phone: ________________

Name: ____________________________ Relationship: ____________ Phone: ________________

By signing below, I authorize Colorectal Health Northwest, LLC personnel to communicate by mail, phone and/or voice mail message.

Patient Signature: ____ Date: ________________