

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.

**Consent to Email or Text Usage for Appointment Reminders and Other Healthcare Communications:**

Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information. If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or text address from the Practice. **The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).**

**I understand I may receive text messages from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information, and that I may opt-out of receiving emails and text messages by submitting a request in writing.**

**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.**

\_\_\_\_\_  
**Signature of Patient** or Personal Representative

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Printed Name of Patient** or Personal Representative

\_\_\_\_\_  
**Relationship to Patient**