Allied Digestive Health

Phone 732.702.1039
Fax 732.548.7408

187 NJ-36 Suite 230,
West Long Branch, NJ 07764

Patient HIPAA Consent Form

Patient Name: ____________________________
DOB: _____________________

Receipt of Notice of Privacy Practices

Our Notice of Privacy Practices provides information about how we may use or disclose your protected health information (PHI). The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

Changes to Notice of Privacy Practices

The terms of the notice may change. If so, Allied Digestive Health will post any revised notice in our registration area and on our website.

Requesting a Restriction on the Use or Disclosure of PHI

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) allows for the use of your protected health information for treatment, payment, or healthcare operations. You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. Allied Digestive Health is not required to agree with this restriction, but if we do, the restriction will be binding on the practice as a whole.

By signing this form, I understand that:

- My protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- Allied Digestive Health reserves the right to change its Notice of Privacy Practices from time to time and will post any revised notice in its registration area or on its website.
- I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.
- I have the right to revoke this consent in writing, except to the extent that you have taken action relying on this consent.

By signing this form, you consent to our use and disclosure of your protected health information and to be contacted in the following manner:

Primary Telephone # ________________

Ok to leave a voicemail message to **call back only**
Ok to leave a voicemail message **with results and detailed information, including billing.**

Secondary Phone # ________________

Ok to leave a voicemail message to **call back only**
Ok to leave a voicemail message **with results and detailed information, including billing.**

By providing the above telephone numbers, I consent to delivery of telephone calls or text messages from Allied Digestive Health, its affiliated practices, and/or third parties acting on behalf of Allied Digestive Health to me at the phone numbers I

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have provided above for appointment reminders or cancellations, billing, payment and account reminders, patient satisfaction surveys, invitations to take part in mobile applications that assist with my treatment, and other informational messages. These calls and text messages may be made using an automatic telephone dialing system or prerecorded or artificial voice.

Revocation of Consent

You have the right to revoke this consent at any time in writing, signed by you. However, such a revocation will not be retroactive and any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

I have reviewed this consent form and hereby give my permission to Allied Digestive Health to use and disclose my Protected Health Information in accordance with these guidelines.

____ ___________________
Signature of Patient or Patient Representative Date

____
Name of Patient Representative

Relationship to patient (if minor): _________________________________