Allied Digestive Health

Advanced Gastroenterology Associates
Atlantic Coast Gastroenterology Associates
Gastroenterologists of Ocean County
Middlesex Monmouth Gastroenterology
Monmouth Gastroenterology
Red Bank Gastroenterology Associates
Shore Gastroenterology Associates

# Consent for Use and Disclosure of Protected Health Information (PHI)

Use and Disclosure of PHI
Your PHI will be used by Allied Digestive Health, or disclosed to others, for the purpose of treatment, obtaining payment, or supporting the day to day healthcare operations of the practice.

Requesting a restriction on the Use or Disclosure of your information
You may request a restriction on the use or disclosure of your protected health information. Allied Digestive Health may agree to restrict the use or disclosure of your protected health information. If ADH agrees to your request, the restriction will be binding on practice as a whole. Unauthorized use and disclosure of PHI is a violation of an agreed upon restriction and will be a violation of federal privacy standards.

I give consent to be contacted in the following manner:

*Primary Telephone #* _____

- ☐ Do not call this number
- ☐ Ok to leave message to **call back only**
- ☐ Ok to leave message **with results and detailed information, including billing.**

*Secondary Phone #* _____

- ☐ Do not call this number
- ☐ Ok to leave message to **call back only**
- ☐ Ok to leave message **with results and detailed information, including billing.**

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Other persons authorized to receive my health information:

Name: _____Relationship:_____ Phone: _____

Name: _____Relationship: _____ Phone: _____

Revocation of Consent
You may revoke this consent in the use and disclosure of you Protected Health Information at any time. You may revoke this consent in writing. Any use of 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

_____
Printed Name of Patient or Patients Representative