Gastroenterology Specialists of Southwest Florida, P.A.
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Diplomate, American Board of Internal Medicine

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PATIENT CONSENT FORM HIPAA COMPLIANT

With my consent, Gastroenterology Specialists of Southwest Florida, P.A. ("The Practice"), may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

I have the right to review the notice of privacy practices prior to signing this consent. The practice reserves the right to revise its notice of privacy practices at any time. A revised notice of privacy practices may be obtained by forwarding a written request to the practice at the address listed on this form.

With my consent, the practice may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any calls pertaining to my clinical care, including laboratory results, among others. With my consent, the practice may mail or email to my home, or other designated location, any items that assist the practice in carrying out TPO, such as appointment reminders, patient's statements and others.

I have the right to request that the practice restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to the practice's use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, the practice may decline to provide treatment to me.

I wish to allow the following person(s) access to my medical record.

Name	Relationship
Name	Relationship

Signature: _____ Date: _____