Advanced Gastroenterology of Central Florida

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DR. VINAY KATUKURI

HIPAA – CONSENT FORM FOR PATIENT

Acknowledgment of Receipt of Notice of Notice of Privacy Policies and consent for Disclosure for Treatment, Payment and Operations.

ACKNOWLEDGEMENT AND CONSENT

By signing below, I hereby acknowledge that (if requested) I have been provided with a copy of this office's Notice of Privacy Practices and have therefore been advised of how my protected health information may be used and disclosed by this office. I have also been advised of how I may obtain access to and control this information. In addition, by signing below, I hereby consent to the use and disclosure of my health information for treatment purposes, payment activities and healthcare operations of the office as described in the Notice.

Signature of Patient or Personal Representative:

_____

Print Name of Patient

_____

Print Name of Personal Representative (if applicable) & description of legal authority

_____

Date

_____