

**Georgia**  
**Colon & Rectal**  
Surgical Associates, P.C.

Dr. \_\_\_\_\_

Account #: \_\_\_\_\_

**Patient Information Form**

**Patient Name:** \_\_\_\_\_  
(First) (M.I.) (LAST) (Suffix: Jr., M.D.)

Apt., Bldg., Unit, Etc.: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell / Work/ Other \_\_\_\_\_

Email Address: \_\_\_\_\_

Sex  M  F Marital Status  M  S  D  W

Date of Birth (MM/DD/YY) \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security Number \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_

Emergency Contact Relationship \_\_\_\_\_

Emergency Contact Phone Number \_\_\_\_\_

Referring Doctor \_\_\_\_\_ Phone \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ PCP Phone \_\_\_\_\_

**Primary Insurance** Effective Date: (MM/DD/YY) \_\_\_\_/\_\_\_\_/\_\_\_\_

Company Name: \_\_\_\_\_

Group #: \_\_\_\_\_ Policy #: \_\_\_\_\_

Please provide the following information on the policy subscriber below:

Subscriber Name \_\_\_\_\_ Sex  M  F  
(Policyholder's Name)

Social Security Number \_\_\_\_\_ Date of Birth (MM/DD/YY) \_\_\_\_/\_\_\_\_/\_\_\_\_

Subscriber's Employer \_\_\_\_\_

Employer Address \_\_\_\_\_ Suite \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Work Phone Number \_\_\_\_\_ Ext. \_\_\_\_\_

I hereby authorize the release of any medical information, including HIV/AIDS confidential information, necessary to process insurance claims or any medical information that is required for healthcare related utilization review or quality assurance activities. I authorize any physician, hospital, or clinic to provide details of my medical history to Georgia Colon & Rectal Surgical Associates, P.C. I hereby assign and authorize payment to Georgia Colon & Rectal Surgical Associates, P.C. of all medical and/or surgical benefits, including major medical benefits, to which I am entitled under any insurance policy or policies, under any self-insurance program or under any other benefit plan. I understand and acknowledge that this assignment of benefits does not relieve me of my financial responsibility for all medical fees and charges incurred by me or anyone on my behalf, and I hereby accept such responsibility, including, but not limited to, payment of those fees and charges not directly reimbursed to Georgia Colon & Rectal Surgical Associates, P.C. by any insurance policy, self-insurance program or other benefit plan. This authorization shall remain in effect until revoked by me in writing. A photocopy of this authorization shall be considered as effective and valid as the original. I understand that I have the right to receive a copy of this authorization.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

# Georgia Colon & Rectal

SURGICAL ASSOCIATES, P.C.

Name: \_\_\_\_\_

Today's Date: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: Male / Female (circle)

Chief complaint \_\_\_\_\_  
(why are you here?)

## Your Symptoms

(check all that apply)

- Diarrhea  Constipation  Incontinence (loss of bowel control)  
 Abdominal pain  Bloating  Nausea/vomiting  
 Rectal bleeding  Swelling around the anus  Prolapse (tissue coming out of the anus)  
 Anal pain  Itching  Burning

## Past medical history (check all that apply)

- Heart disease  High blood pressure  Stroke  Heart attack \_\_\_\_\_ (year)  
 High cholesterol  Angina or chest pain  Heart murmur  Heart surgery  
 Implanted defibrillator or pacemaker  
 Lung disease  Asthma  Tobacco use \_\_\_\_\_ (packs per day)  
 Diabetes Type I \_\_\_\_\_ Type II \_\_\_\_\_  Low thyroid  
 Cancer If so, what kind? \_\_\_\_\_  
 Crohn's disease or  ulcerative colitis \_\_\_\_\_  
 Irritable bowel syndrome \_\_\_\_\_  Colon polyps \_\_\_\_\_

Medications: \_\_\_\_\_

Daily aspirin? Y/N On Plavix? Y/N On Coumadin? Y/N

Allergies to medications \_\_\_\_\_

## Past Surgical History (please give dates)

Colonoscopy \_\_\_\_\_ Physician \_\_\_\_\_ Date \_\_\_\_\_

Colon surgery \_\_\_\_\_ Physician \_\_\_\_\_

Anal or rectal surgery \_\_\_\_\_ Physician \_\_\_\_\_

Artificial joints \_\_\_\_\_

Heart valves \_\_\_\_\_ On Coumadin? Y/N

Hysterectomy \_\_\_\_\_

Obstetric: \_\_\_\_\_ # pregnancies \_\_\_\_\_ # vaginal deliveries \_\_\_\_\_ # C-sections

History of episiotomy or tear \_\_\_\_\_

Other: \_\_\_\_\_

## Family History:

Relationship to you:

Age at diagnosis:

Breast cancer \_\_\_\_\_

Ovarian cancer \_\_\_\_\_

Uterine cancer \_\_\_\_\_

Thyroid cancer \_\_\_\_\_

Colon / Rectal cancer \_\_\_\_\_

Ulcerative colitis \_\_\_\_\_

Crohn's disease \_\_\_\_\_

Polyps \_\_\_\_\_

FAP \_\_\_\_\_

Other: \_\_\_\_\_

Medical conditions: Diabetes / High cholesterol / Heart disease / Lung disease

# Georgia Colon & Rectal Surgical Associates

770-277-4277  
www.gcrsa.com

## Authorization for Voicemail Delivery of Medical Information

In an effort to provide efficient, quality, patient-friendly medical care by avoiding the "phone tag" issues often associated with informing patients of their test results, we have developed this Authorization for Voicemail Delivery of Medical Information.

HIPAA (Health Insurance Portability & Accountability Act of 1996) provides specific guidelines to protect patient's privacy specifically restricting Protected Health Information (PHI). Detailed information regarding HIPAA, PHI and patient privacy can be found in the Notice of Privacy Practices which you received on your first visit to our office following the enactment of HIPAA. Additional copies of the Notice of Privacy Practices are available from the receptionist.

*I authorize Georgia Colon & Rectal Surgical Associates, and its physicians and employees to leave detailed messages specific to my medical care including test results on the phone number(s) listed below. I understand that once a voicemail message exists it is no longer covered under HIPAA and therefore is not protected from unauthorized access. This authorization is effective \_\_\_\_\_.*

*I understand that this authorization can be revoked at anytime by submitting a written request to the practice. Unless revoked sooner, this authorization to release detailed medical information will expire one (1) year from the effective date listed above.*

Home Voicemail:  Yes  No Phone Number: \_\_\_\_\_

Work Voicemail:  Yes  No Phone Number: \_\_\_\_\_

Cellular Voicemail:  Yes  No Phone Number: \_\_\_\_\_

Speak with spouse/partner:  Yes  No Phone Number: \_\_\_\_\_ Name: \_\_\_\_\_

Other family member:  Yes  No Phone Number: \_\_\_\_\_ Name: \_\_\_\_\_

### **Preferred Pharmacy Information**

Pharmacy Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: Fax: \_\_\_\_\_

e-Prescribing allows your physician to send eligible new prescriptions and refills to your pharmacy electronically. It is a highly convenient process that maximizes prescription accuracy and eliminates the need for patients to keep up with paper prescriptions. It significantly lessens the wait time associated with dropping off prescriptions to your pharmacy after your visit or having a staff member to call it in. Prescriptions arrive to your pharmacist instantaneously.

I would like a copy of this notice for my records:  Yes  No

Patient Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Georgia Colon & Rectal Surgical Associates

## Financial and Insurance Policy

Every individual's insurance policy is different, so please take the time to become familiar with your insurance plan. Your insurance company may or may not cover certain procedures. To help avoid uncovered services, it is important that you understand your plan's coverage by referring to your insurance handbook or contacting your insurance provider prior to your appointment.

### Here are a few questions you may want to ask your insurance provider:

- 1) *Is a referral needed from my Primary Care Physician (PCP) in order to see a specialist?*
- 2) *Does my policy require an office appointment co-payment? (co-payment is the dollar amount required to be paid by the patient at the time of service).*

### Policy:

- If your health care plan requires a referral from your primary care physician (PCP) and one is not provided to GCRSA prior to your visit, fees for your office visit will be your responsibility and paid at the time of service. Obtaining a referral is the patient's responsibility.
- Payment is due for any open balance within 30 days from receipt of your billing statement.
- Past due balances must be paid in full prior to any additional visits unless advanced arrangements have been made with our Business Office.
- Patients without insurance will be considered as "self pay" and required to pay all office visit fees at the time of service, and a 50% deposit of our allowable charge will be required before a surgical procedure will be scheduled, with the balance due paid within 30 days.
- We appreciate your kind consideration by providing us with 24 hour notice when canceling or rescheduling your office visit.
- Due to the increased administrative costs for reserving a hospital operating room, and coordinating our surgeon's schedule, we will reserve the right to access up to a \$200 fee for your scheduled surgery not canceled or rescheduled within 3 business days.
- GCRSA requires a 10 business day return window for administrative services. Administrative services and fees includes, but is not limited to: *filling out forms for FMLA, short / long term disability (\$30) and making copies of medical records (\$25).* **Payment is required prior to being picked up, faxed or mailed.**

I have read and agree to the terms of Georgia Colon & Rectal Surgical Associates Financial and Insurance Policy.

Patient / Guardian responsible for payment signature: \_\_\_\_\_

Date: \_\_\_\_\_

# Georgia Colon & Rectal Surgical Associates

770-277-4277

[www.qcrsa.com](http://www.qcrsa.com)

## **HIPAA Privacy Regulations As of April 14, 2003**

HIPAA Privacy Regulations As of April 14, 2003 Patient privacy has always been a top priority at Georgia Colon & Rectal Surgical Associates. Our staff and physicians are dedicated to protecting our patients' privacy. The new HIPAA privacy regulations provide medical practices and patients with an additional means to help guarantee that patient privacy is a top priority for all providers – physicians, hospitals and pharmacies – throughout the United States.

The new rules are beneficial for patients because they strengthen and set national standards for the privacy of your medical information. They guarantee strong privacy rights to patients and families in a way that puts common sense ahead of bureaucracy. Specifically, the rules give patients more control over who can see their private medical information.

As an organization dedicated to safeguarding patients' medical records, we want patients to fully understand their medical privacy rights and know how their medical information is used. However, our number one job is to care for our patients – nothing should interfere with that. The final HIPAA Privacy Rule finds the right balance. It protects patient information but allows all essential activities to go on, which benefits all of us.

Make no mistake; the new rules have required sweeping operational changes. They touch every employee, physician and contractor of our medical practice. Nonetheless, they are the right thing to do, and Georgia Colon & Rectal Surgical Associates is committed to making them work for our patients, their families and our staff.

The enclosed Notice of Privacy Practices outlines specific details regarding HIPAA and your protected health information. In accordance with the federal HIPAA guidelines we ask that you sign a receipt of acknowledgement for the Notice of Privacy Practices. After reviewing the Notice of Privacy Practices, please let us know if you have any questions regarding HIPAA we can answer for you.

### **NOTICE OF PRIVACY PRACTICES**

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU  
(AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED,  
AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY  
IDENTIFIABLE HEALTH INFORMATION.**

**PLEASE REVIEW THIS NOTICE CAREFULLY.**

## A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your IIHI
- Your privacy rights in your IIHI
- Our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

Please realize in some instances, Georgia will have special laws concerning the use and disclosure of certain types of health information, such as mental health information, substance abuse information, HIV/AIDS information and genetic testing information.

## B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Georgia Colon & Rectal Surgical Associates  
Attention: Privacy Officer  
5555 Peachtree Dunwoody Road  
Suite 206  
Atlanta, GA 30342  
770-277-4277

## C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your IIHI.

**1. Treatment:** Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory or radiology tests, and we may use the results to help us reach a diagnosis. We might use your IIHI in order to write a prescription for you, or we might disclose your IIHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice – including, but not limited to, our doctors and nurses – may use or disclose your IIHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your IIHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your IIHI to other health care providers for purposes related to your treatment.

**2. Payment:** Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for

benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your IIHI to bill you directly for services and items. We may disclose your IIHI to other health care providers and entities to assist in their billing and collection efforts.

**3. Health Care Operations:** Our practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your IIHI to other health care providers and entities to assist in their health care operations.

**4. Appointment Reminders:** Our practice may use and disclose your IIHI to contact you and remind you of an appointment.

**5. Treatment Options:** Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.

**6. Health-Related Benefits and Services:** Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you.

**7. Release of Information to Family/Friends:** Our practice may release your IIHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to the pediatrician's office for treatment of a cold. In this example, the babysitter may have access to this child's medical information.

**8. Disclosures Required By Law:** Our practice will use and disclose your IIHI when we are required to do so by federal, state or local law.

#### **D. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES**

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

**1. Public Health Risks:** Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:

- Maintaining vital records, such as births and deaths
- Reporting child abuse or neglect
- Preventing or controlling disease, injury or disability
- Notifying a person regarding potential exposure to a communicable disease
- Notifying a person regarding a potential risk for spreading or contracting a disease or condition
- Reporting reactions to drugs or problems with products or devices
- Notifying individuals if a product or device they may be using has been recalled
- Notifying appropriate government agency (ies) and authority (ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
- Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

**2. Health Oversight Activities:** Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

**3. Lawsuits and Similar Proceedings:** Our practice may use and disclose your IHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

**4. Law Enforcement:** We may release IHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
- Concerning a death we believe has resulted from criminal conduct
- Regarding criminal conduct at our offices
- In response to a warrant, summons, court order, subpoena or similar legal process
- To identify/locate a suspect, material witness, fugitive or missing person
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)

**5. Deceased Patients:** Our practice may release IHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

**6. Organ and Tissue Donation:** Our practice may release your IHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

**7. Research:** Our practice may use and disclose your IHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your IHI for research purposes except when an Institutional Review Board or Privacy Board has determined that the waiver of your authorization satisfies the following: (i) the use or disclosure involves no more than a minimal risk to your privacy based on the following: (A) an adequate plan to protect the identifiers from improper use and disclosure; (B) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (C) adequate written assurances that the PHI (Protected Health Information) will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted; (ii) the research could not practicably be conducted without the waiver; and (iii) the research could not practicably be conducted without access to and use of the PHI.

**8. Serious Threats to Health or Safety:** Our practice may use and disclose your IHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

**9. Military:** Our practice may disclose your IHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

**10. National Security:** Our practice may disclose your IHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

**11. Inmates:** Our practice may disclose your IHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

**12. Worker's Compensation:** Our practice may release your IIHI for workers' compensation and similar programs.

#### **E. YOUR RIGHTS REGARDING YOUR IIHI**

You have the following rights regarding the IIHI that we maintain about you:

**1. Confidential Communications:** You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to *Georgia Colon & Rectal Surgical Associates, 5555 Peachtree Dunwoody Road, suite 206, Atlanta, Georgia 30342* specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.

**2. Requesting Restrictions:** You have the right to request a restriction in our use or disclosure of your IIHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your IIHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your IIHI, you must make your request in writing to *Georgia Colon & Rectal Surgical Associates, 5555 Peachtree Dunwoody Road, suite 206, Atlanta, Georgia 30342*. Your request must describe in a clear and concise fashion: (a) The information you wish restricted; (b) Whether you are requesting to limit our practice's use, disclosure or both; and (c) To whom you want the limits to apply.

**3. Inspection and Copies:** You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to *Georgia Colon & Rectal Surgical Associates, 5555 Peachtree Dunwoody Road, suite 206, Atlanta, Georgia 30342* in order to inspect and/or obtain a copy of your IIHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews. If our practice denies your request to inspect and/or copy your IIHI, you may request in writing that our practice provide your records to another healthcare provider.

**4. Amendment:** You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to *Georgia Colon & Rectal Surgical Associates, 5555 Peachtree Dunwoody Road, suite 206, Atlanta, Georgia 30342*. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the IIHI kept by or for the practice; (c) not part of the IIHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

**5. Accounting of Disclosures:** All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your IIHI for non-treatment, non-payment or non-operations purposes. Use of your IIHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to *Georgia Colon & Rectal Surgical Associates, 5555 Peachtree Dunwoody Road, suite 206, Atlanta, Georgia 30342*. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is

free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

**6. Right to a Paper Copy of This Notice:** You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact our Privacy Officer 770-277-4277.

**7. Right to File a Complaint:** If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact our Privacy Officer 770-277-4277. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

**8. Right to Provide an Authorization for Other Uses and Disclosures:** Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your IHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your IHI for the reasons described in the authorization. Please note, we are required to retain records of your care. Again, if you have any questions regarding this notice or our health information privacy policies, please contact our Privacy Officer.

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Print Patient Name

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Patient Signature

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Date