Patient Consent: Use of My Health Information

I consent to the use or disclosure of my protected health information by **Rochester Colon Rectal Surgeons, PC.**, ("the Practice"), for diagnosing or providing treatment to me, obtaining payment for my health care bills and to conduct health care operations of the Practice.

When I have been directed to seek emergent care at a hospital or emergent care center by the Practice, I consent to the disclosure of my health information related to that visit.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. The Practice is not required to agree to the restrictions that I may request. Restrictions need to be given in writing for review. However, if the Practice agrees to a restriction that I request, the restrictions are binding on the Practice.

I have the right to revoke this consent, in writing, at any time, except to the extent that the Practice has taken action in reliance on this consent.

My "protected health information" means health information, including demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or healthcare clearing house. This protected health information relates to my past, present or future physical or mental health condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review the Practice's Notice of Privacy Practices prior to signing this document. The notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the Practice. The Notice of Privacy Practices also describes my rights of the Practice's duties with respect to my protected health information.

I understand that the Notice of Privacy Practices is posted in the waiting room. The Practice reserves the right to change the Notice of Privacy Practices. I understand that I may request a copy of the Notice of Privacy Practices by asking the Receptionist for during regular business hours.

I hereby give permission to Rochester Colon Rectal Surgeons PC, to leave voice messages on home and or cell phone, as well as send mail, call, or text regarding appointment reminders, changes in appointments, financial responsibility and other information necessary to facilitate the schedule of this office and the convenience of the patient. We will also send billing statements and or letters regarding your treatment through the mail OR portal. If you are participating in patient portal this is another method of notification related to your treatment or other information related to your care will be sent to your ACTIVE portal account.

ELECTRONIC SIGNATURE WILL BE OBTAINED AT TIME OF VISIT

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Signature of Patient (or representative) Date Print Name of Patient (and representative)

I give **Rochester Colon Rectal Surgeons, P.C.** permission to share my health information with the following individual(s), other than your Doctors:

_______________________________ _______________________________

NAME RELATIONSHIP

_______________________________ _______________________________

NAME RELATIONSHIP

Revised 10/13, 6/14, 11/15, 10/16