NOTICE OF CONSENT

PATIENT NAME ____ **DOB**_____________________________

_________ **Notice of Privacy Practices:** I acknowledge that I have either received or was offered a copy of the GHP, PLLC Notice of Privacy Practices from.

_________ **Financial Policy:** I acknowledge that I have received and reviewed the GHP, PLLC Financial Policy.

_________ **Assignment of Benefits – Signature on File:** I authorize the payment of insurance benefits to be made directly to GHP, PLLC for any and all services rendered. I authorize the release of medical information necessary for the determination of benefits to my insurance carrier(s) and its agents, including Centers for Medicare & Medicaid Services (CMS).

_________ **Patient Portal:** I authorize my provider or his/her practice staff to contact me via the practice patient portal.

_________ **Electronic Notification:** I authorize my provider or his/her practice staff to contact me via email. I understand that information which is not sent in an encrypted manner could be at risk to be accessed inappropriately.

_________ **Telephone Notification:** Under the Telephone Consumer Protection Act (TCPA), I acknowledge that I am giving my prior express and written consent to GHP, PLLC and its affiliates and partners that they may have authorization to contact me via auto-dialer, pre-recorded voice message and/or live call for any communication associated with my account.

Permission to Leave Messages: I authorize GHP, PLLC to contact me and leave detailed health and billing information on the voicemail of the below listed phone numbers.

( )	( )

Permission to Disclose Medical & Billing Information: I authorize Gastroenterology Health Partners, PLLC (GHP, PLLC) to share and/or disclose medical and billing information to family and/or individuals listed below who are directly related to my care or responsible for payment of services related to my care.

NAME	RELATIONSHIP	EMAIL	PHONE
			( )
			( )
			( )

I understand that I have the right to revoke this authorization at any time by written notification to Gastroenterology Health Partners, PLLC; however, the revocation will not apply to information that already has been released in reliance upon this authorization. I also understand that this authorization is valid until further notice or written revocation by me. I understand that it is my responsibility to advise Gastroenterology Health Partners, PLLC of changes to my contact information or my communication preferences. I understand and acknowledge that the confidential health care information disclosed to the above-named individuals may be subject to re-disclosure by those individuals and may no longer be protected by federal privacy regulations. Gastroenterology Health Partners, PLLC expressly reserves the right to disclose information to others who may not be on the list if and to the extent allowed by HIPAA, including but not limited to disclosures for treatment, payment, or healthcare operations.

_____________________________________ _________________________________ ____________________

Patient Signature / Legal Representative **Printed Name** **Date**