ALASKA
COLORECTAL SURGERY

907-222-1401

June M. George, MD *Kerrie R. Bossard, MD* *Daniel C. Rossi, DO*

INDIVIDUAL CONSENT

CONSENT TO THE USE AND DISCLOSURE OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION FOR TREATMENT, PAYMENT, AND/OR HEALTH OPERATIONS

I understand that as a part of my health care, AKCRS, PC receives, originates, maintains, discloses, and uses individually identifiable health information, including, but not limited to, health records and other health information describing my health history, symptoms, examination and test results, diagnoses, treatment, treatment plans, and billing and health insurance information. I understand that AKCRS, PC and its physicians, other health care professionals, and staff may use this information to perform the following tasks: Diagnose my medical/psychiatric/psychological condition, plan my treatment and care, communicate with other health professionals concerning my care, document services for payment/reimbursement, conduct routine health care operations, such as quality assurance.

I understand that my medical records may contain sensitive information including, but not limited to, the information listed below. I authorize this to be used, disclosed, received and /or exchanged for purposes of my treatment. Please disclose in the consent section if you object to use of one or more of the following types of information:

HIV/AIDS, substance abuse, developmental disabilities, mental health, sexually transmitted diseases, and communicable diseases.

A copy of the practice's **NOTICE OF PRIVACY PRACTICES** has been available for my review that fully explains the uses and disclosures that this practice will make with respect to my individually identifiable health information. I understand that I have the right to review this NOTICE before signing this consent. AKCRS, PC has given me sufficient time to review this NOTICE and has answered any questions that I had to my satisfaction. I also understand that AKCRS, PC cannot use or disclose my individually identifiable health information other than as specified on the NOTICE. I also understand that AKCRS, PC reserves the right to change its notice and the practices detailed therein and will provide me with a copy of the revised notice by mail to the address that I have provided.

I understand that I do not have to consent to the use or disclosure of my individually identifiable health information for treatment, payment, or health operations, but that if I do not consent, AKCRS, PC may refuse to provide me health care services unless applicable state or federal law requires AKCRS, PC to provide such services.

I understand that I have the right to request restrictions on the use or disclosure of my individually identifiable health information to carry out treatment, payment, or health operations. I further understand that AKCRS, PC is not required to agree to the requested restriction but that, if it does agree, it must honor the restriction unless I request that I stop doing so or AKCRS, PC notifies me that it is no longer going to honor the request.

I understand that I have the right to object to the use and/or disclosure of my individually identifiable health information to family members.

<u>Please see other side for Consent and Signature</u>

PLEASE INITIAL NEXT TO THOSE APPLICABLE:

_________ I **consent** to the use of my individually identifiable health information (IIPI) ***as described on previous side*** for treatment, payment, and health care operations.

_________ I **consent** to the use of my individually identifiable health information (IIPI) as described on previous side for treatment, payment, and health care operations, ***<u>but</u> with the following changes***:

____

We respect your right to privacy regarding your medical information. We will NOT share your information with any family member, friend, significant other, or spouse without your written consent. If you would like to authorize us to share your information with someone, please list them below.

I **consent** to allowing the providers and staff of AKCRS, PC to discuss my PHI with my family members, significant other, or my personal representative

NAME:_____________________________________**Relationship:**_______________**Phone:**_____________

NAME:_____________________________________**Relationship:**_______________**Phone:**_____________

OR

_________ I **restrict** the providers and staff of AKCRS, PC from discussing my PHI with anyone other than myself.

I understand that I may revoke this consent in writing, but that revocation will not be affect to the extent that AKCRS, PC has already taken action in reliance on my earlier effective consent.

Signature of Patient or Legal Representative:

_____________________________________ Date: _________________________________

Witness: ______________________________

Alaska Colorectal Surgery, P.C ~ 2751 DeBarr Road, Ste. 280 ~ Anchorage, AK 99508
Phone: (907) 222-1401 Fax: (907) 222-1402