Johns Creek Gastroenterology

Clive Albert MD AGAF
Arumugam Natesan MD

Patient Consent for Use and Disclosure Of Protected Health Information

I hereby give my consent for Johns Creek Gastroenterology PC to use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Johns Creek Gastroenterology, PC's Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. The Johns Creek Gastroenterology, PC reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Johns Creek Gastroenterology PC Privacy Office at 1100 Northside Forsyth Drive, Suite 330, Cumming, GA 30041.

With this consent, the Johns Creek Gastroenterology PC may call my home or other alternative location and leave a message on voice mail or in person in reference to any items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, the Johns Creek Gastroenterology PC may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements, as long as they are marked Personal and Confidential.

With this consent, the Johns Creek Gastroenterology PC may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have a right to request that the Johns Creek Gastroenterology, PC restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to the Johns Creek Gastroenterology, PC use and disclosure of my PHI to carry out TPO. If I elect not to sign this form, I will restrict access by signing the Request For Limitation and Restrictions of PHI.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, the Johns Creek Gastroenterology PC may decline to provide treatment to me.

_____	_____	_____
Signature of Patient or Legal Guardian	Print Name of Patient of Legal Guardian	Date

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Request For Limitation and Restrictions of Protected Health Information

Patients please note: The practice is not required to agree to your request. Please see our Notice of Privacy Practices for more information regarding such requests.

Patient Name: _____ Date of Birth: _____

Patient Address: _____

_____

_____

Please check all the information you do **not** want to be given out. By restricting access to your. information, JCG may be unable to give information to Insurance Companies or referring physicians.

- ☐ Home Phone Number
- ☐ Home address
- ☐ Occupation
- ☐ Spouse's Name
- ☐ Office Visit Notes
- ☐ Referring physicians
- ☐ Answering machine at home
- ☐ Patient History
- ☐ Office Phone Number
- ☐ Office Address
- ☐ Name of Employer
- ☐ Spouse's office phone Number
- ☐ Hospital Notes
- ☐ Prescription Information
- ☐ Answering machine at office

How would you like your PHI Restricted? _____

_____

_____ _____

Signature of Patient or Legal Guardian Date

1100 Northside Forsyth Drive, Suite 330, Cumming, GA 30041
Emory Johns Creek Physicians Plaza, 6335 Hospital Prkway, Suite 305, Johns Creek GA 30097
Tel: (770) 889-9901 Fax: (770) 889-9088
www.johnscreekgastro.com

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Receipt of Notices of Privacy Practices
Written Acknowledgement Form

I have received a copy of Johns Creek Gastroenterology PC Notice of Privacy Practices.

_____ _____
Patient signature or Legal Guardian Date

_____
Print Name of Patient or Legal Guardian

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