CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

The Berks Center for Digestive Health ("Surgery Center") and ("Anesthesia Group") have developed a joint notice of their privacy and are using this joint consent form in order to simplify the administrative process for patients. The physicians and Certified Registered Nurse Anesthesiasts provide anesthesia services at Berks Center for Digestive Health. The Surgery Center and the Anesthesia Group are separate legal entities and are each separately required to comply with state and federal law. They must each comply with the notice and this consent form. The Surgery Center and the Anesthesia Group are not responsible for the other's failure to comply with the notice or this consent form. By signing this consent form, you agree to allow both the Surgery Center and the Anesthesia Group to use your individually identifiable health information for the purposes described below. You also acknowledge that you have been offered the notice that describes the privacy practices of both the Surgery Center and the Anesthesia Group. I understand that the privacy notice will be available to me in the future at my request.

I understand that as part of my healthcare, the Surgery Center and the Anesthesia Group create and maintain health records describing my health history. I understand that the Surgery Center and the Anesthesia Group may use this information as:

- 1. a basis for planning my care and treatment;
- 2. a means of communication among many health professionals who contribute to my care;
- 3. a means by which third-party payors can verify that services billed were actually provided; and
- 4. a tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals.

I hereby consent to the Surgery Center's and the Anesthesia Group's use and disclosure of my individually identifiable health information for the purposes listed above and other purposes relating to my treatment, the payment of my health care, and other health care operations of the Surgery Center and the Anesthesia Group. The privacy notice, which describes the obligations of the Surgery Center and the Anesthesia Group regarding their use and disclosure of my individually identifiable health information and my rights regarding this information. I also understand that the Surgery Center and the Anesthesia Group reserve the right to change their notice and practices. If the surgery Center and the Anesthesia Group change the notice, I can obtain a revised copy by request. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or other healthcare operations and that the Surgery Center and the Anesthesia Group are not required to agree to the restrictions requested. If the Surgery Center or the Anesthesia Group agree to such restrictions, however, they must comply with such restrictions. I understand that if I do not sign the consent, the center will not treat me.

I request the following restrictions to the use or disclosure of my health information.		
Effective Date of Notice: April 14, 20	03, revised April 3, 2017	
X Signature of patient or legally authorize	Date:	

