MONTANA GASTROENTEROLOGY
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HIPAA PRIVACY / CONSENT TO TREAT / FRIENDS & FAMILY AUTHORIZATION FORM

HIPAA CONSENT:

I understand that I have certain rights to privacy regarding my protected health information according to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize the clinic to use and disclose my protected health information for the purpose of:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment).
- Obtaining payment from insurance or third-party benefit plans.
- The day-to-day health care operations of the clinic such as quality assessments and provider certifications.

CONSENT TO TREAT AND BILL INSURANCE:

I authorize Montana Gastroenterology to provide medical treatment and file my insurance and third-party benefits claims. I authorize payments of medical benefits to be paid directly to the clinic. I accept full responsibility of all services and charges not paid for by my insurance company or third-party benefit plan. I accept full responsibility for all charges in the event that I have no insurance or third-party benefits.

FRIEND & FAMILY AUTHORIZATION:

This authorization grants permission to the designated person(s) named below to all of the following: • Make or confirm appointments • Verbal access to x-ray, laboratory, test findings, diagnosis, prognosis, and treatment plans by telephone or other common means of communication • Pick up sample medications • Access to my financial health information

I hereby authorize **Montana Gastroenterology** to use and disclose my individually identifiable health information as described above. The below person(s) is who I have designated to receive my individually identifiable health information.

FRIEND/FAMILY NAME	PHONE NUMBER

I understand that this authorization will be effective for the lifetime of the patient unless revoked in writing OR expires on_____. I understand that I may revoke this authorization at any time by notifying the Medical Records Department in writing; however, the revocation will have no effect on disclosures made prior to the receipt of the revocation. I understand that my treatment cannot be conditioned on whether I sign this authorization.

I authorize messages to be left on my phone regarding my protected health information.
(Circle one) YES or NO

_____ _____

PATIENT / LEGAL CUSTODIAN SIGNATURE **DATE**