Island Endoscopy Center, LLC

1175 MONTAUK HIGHWAY SUITE 1
WEST ISLIP, NY 11795
PHONE# (631) 376-0001

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, ISLAND ENDOSCOPY CENTER, LLC may use and disclose protected health information (pm) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Island Endoscopy Center, LLC's Notice of Privacy for 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, Island Endoscopy Center, LLC reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to: Island Endoscopy Center, LLC at 1175 Montauk Highway Suite 1, West Islip, NY 11795.

With my consent, Island Endoscopy Center, LLC may call home, or other designated location, and leave a message on voice mail, answering machine, or in person in reference to any items that assists the Center in carrying out TPO, such as appointment reminders, insurance items, and any call pertaining to my clinical care, including pathology results among others.

With my consent, Island Endoscopy Center, LLC may mail to my home or other designated location any items, that assist the Center in carrying out TPO, such as appointment reminders cards and patient statements. I have the right to request Island Endoscopy Center, LLC to restrict how it uses or discloses my pm 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 Island Endoscopy Center, LLC's use and disclosure of my PHI to carry out TPO,

I may revoke my consent in writing except to the extent that the Center has already made disclosure in reliance upon my prior consent. If I do not sign this consent, Island Endoscopy Center, LLC may decline to provide treatment to me.

_____ _____

Signature of Patient Date

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Print Name of Patient or Legal Guardian