PIEDMONT COLORECTAL ASSOCIATES, P.C.

35 Collier Road, N.W. Ste 475
Atlanta, GA 30309

1240 Eagles Landing Pkwy, Ste 240
Stockbridge, GA 30281

404-351-7900 FAX 404-351-7901
www.piedmontcolorectal.com

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Piedmont Colorectal Associates, P.C. to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (Piedmont Colorectal Associates, P.C.'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. Piedmont Colorectal Associates, P.C. 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 Piedmont Colorectal Associates, P.C.'s Privacy Officer at 35 Collier Road, N.W., Suite 475, Atlanta, GA 30309.

With this consent, Piedmont Colorectal Associates, P.C. may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Piedmont Colorectal Associates, P.C. 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.

I have the right to request that Piedmont Colorectal Associates, P.C. 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 Piedmont Colorectal Associates, P.C.'s use and disclosure of my PHI to carry out TPO.

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, Piedmont Colorectal Associates, P.C. may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____ _____
Patient's Name Date

_____
Print Name of Patient or Legal Guardian