DIGESTIVE DISEASE & ENDOSCOPY CENTER, PLLC
DR. PANKAJ SHARMA * YUEN SAN YEE, M.D. * NARENDRA SIDDAIAH, M.D.

Patient Name: ________________________ Date of Birth: ________________

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting our medical records department and asking for the Privacy Officer.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed and how your information can be accessed. You may ask the receptionist who checked you in for a copy to read and take home. There are copies in the waiting areas for reading also and on the walls.

Please list the individuals you wish to participate in your care. If you wish limited access information to be shared please check mark restricted.
Restricted ____

____
Name of Individual Relationship to Patient Phone Number

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Name of Individual Relationship to Patient Phone Number

I agree to permit DDEC to request and obtain previous medical records from or forward records to other providers if deemed necessary to provide me with proper care and treatment.

I agree to have my biopsy results and or reports mailed to me.

I agree to be contacted regarding treatment options and health-related benefits regarding medical options that may improve my quality of life.

I agree to the release of all my insurance and medical information to other health care providers, my insurance company. Medicare or any third payer to facilitate health care, processing of claims and audit of payments. I understand that the information released may need to include records regarding HIV/AIDS, sexually transmitted diseases, mental health and drug and alcohol abuse treatment information.

I agree to be financially responsible for any non-covered services.

I agree (if applicable) to give permission to have the following persons bring my minor child into the practice for medical treatment. We will not see any child without supervision by authorized adult.

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Name of Individual *Phone number* *Parent Signature*

CONSENT TO PARTICIPATE IN HEALTH INFORMATION EXCHANGE

Dr. Sharma, Dr. Yee, and Dr. Siddaiah, have agreed to participate in Harrison Medical Center's Health Information Exchange (HIE). An HIE provides the technology necessary for your health care providers to share important elements of your care with other healthcare providers to carry out routine treatment, payment, and healthcare operations. This means that if you were hospitalized at Harrison Medical Center, important healthcare information about you, such as allergies and current medications, will be immediately available to the medical staff treating you. In addition, notes about your care while hospitalized, as well as any laboratory, imaging or other testing will be immediately available to your healthcare provider. Ultimately this leads to better, safer, more efficient care for you and your family.

- ☐ **Yes to participate**: The named patient, or his/her representative, gives consent to licensed medical professionals to use and to disclose his/her protected health information to carry out routine treatment, payment, and health care operations for continuity of care.

- ☐ **NO to participate:** The named patient, or his/her representative, refuses or revokes consent to licensed medical professionals to use and to disclose his/her protected health information to carry out routine treatment, payment, and health care operations for continuity of care.

By my signature below I hereby acknowledge that I have been made aware of the availability of the Notice of Privacy Practices, Consent to participate in Health Information Exchange, and Patient Consent.

______________________________	______________________________
Printed Patient Name	Printed Guardian or POA Name
Signature	Date
Printed Staff Name	Staff Signature