Name: _____ DOB: _____

PHONE MESSAGE CONSENT

I give Peak Gastroenterology Associates, PC (PGA) and Front Range Endoscopy Centers, LLC (FREC) permission to leave a phone message regarding my medical care with the following: medical care information including labs, imaging, endoscopy, and other test results as well as appointment times. If I wish to withdraw the consent, I must provide written notice to PGA and FREC stating the date of the requested withdrawal.

My home voicemail: _____

My office voicemail: _____

My cell voicemail: _____

My spouse or other family names and numbers I give permission to leave messages with and/or discuss my medical history:

Name/Relationship: _____/_____ Phone: _____

Name/Relationship: _____/_____ Phone: _____

Name/Relationship: _____/_____ Phone: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF HEALTH INFORMATION PRIVACY PRACTICE

Effective April 14, 2003, the Health Insurance Portability and Accountability Act (HIPPA) requires all health care facilities have policies regarding the protection of health information. PGA and FREC have policies in place regarding how we handle and protect the information about health care you receive in our facilities. The following is a summary of our policies regarding our responsibilities and your rights. You may request a copy of this notice at any time. This practice has the right to change its privacy practices and you may obtain any revised notices.

PGA/FREC RESPONSIBILITIES

Must make reasonable effort to keep your health information private and confidential and may NOT release information about you/your health care without your written consent except:

- Internally within our facility or other facility to which we refer you
- To process payment from your insurance company or other funding source
- For health care operations (internal quality management activities, audits, etc.)
- To law enforcement officials (where reporting is required by law) or information provided ot health oversight agencies (i.e. Colorado Department of Health)

YOUR RIGHTS

You have the right to:

- See our policies regarding how we handle your private health information
- Request restrictions on the use or disclosure of your health information
- Inspect and copy your health information
- Request an amendment to your health information

PRESCRIPTION DRUG MONITORING PROGRAM DISCLOSURE

If I receive a prescription for a controlled substance (Schedule II through IV) drug, my identifying prescription information will be entered into Colorado's electronic Prescription Drug Monitoring Program (PDMP) when this drug is dispensed to me. My prescription information in the database is a protected health record and cannot be accessed by non-caregivers except as part of an authorized investigation. I have a right to access your information in the PDMP through the Colorado Board of Pharmacy. I may seek corrections to the information as I would my other medical records.

PATIENT'S LEGAL NAME: _____ Signature: _____

If legally authorized representative, then relationship to patient: _____ Date: _____