Illinois Gastroenterology, LLC
a member of Premier Medical Group, LLC
2200 Jacobssen Drive
Normal, IL. 61761

Notice of Privacy Practices and Patient Consent
For Use and Disclosure of Protected Health Information

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MRN#

Patient Name: ____**Date of Birth:** __________________________________
(Please print)
Email: ____**Today's Date:** __________________________________

I understand...

- That under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected health information.
- That Illinois Gastroenterology, LLC /Mid-Central Illinois Gastroenterology , Ltd, a member of Premier Medical Group, LLC - may use or disclose my protected health information for treatment, payment or health care operations - which means for providing health care to me, the patient; handling billing and payment; and, taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.
- That Illinois Gastroenterology, LLC /Mid-Central Illinois Gastroenterology , Ltd, a member of Premier Medical Group, LLC has a detailed document called the **'Notice of Privacy Practices'**. It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.
- That I have the right to read the *'Notice'* before signing this agreement. If I ask, Illinois Gastroenterology, LLC /Mid-Central Illinois Gastroenterology , Ltd, a member of Premier Medical Group, LLC will provide me with the most current *Notice of Privacy Practice.*
- That Illinois Gastroenterology, LLC /Mid-Central Illinois Gastroenterology , Ltd, a member of Premier Medical Group, LLC, a member of Premier Medical Group, LLC policy is to call patients by their first and last names.

My signature below indicates that I have been given the chance to review such copy of the *Notice of Privacy Practices.* My signature means that I agree to allow Illinois Gastroenterology to use and disclose my protected health information to carry out treatment, payment, and health care operations, including release of medical information to my insurance/Medicare carrier to determine benefits payable for related services. I understand that I am financially responsible to the clinic for any charges covered by this authorization. Some costs (i.e. immunizations, Virtual Colonoscopy's) may not be covered by insurance/Medicare. I understand that these costs are my responsibility. I have the right to revoke this consent in writing at any time, except to the extent that Illinois Gastroenterology has taken action relying on this consent.

____ ____________________
SIGNATURE (Patient or Legal Custodian/Authorized Representative) **DATE**

____ ____________________
PRINT NAME **Relationship to Patient**

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our 'Notice' at anytime by contacting : Illinois Gastroenterology, LLC, 2200 Jacobssen Drive, Normal, IL., 61761 309-451-1123

***ADDITIONALLY, you grant Illinois Gastroenterology, LLC/Mid-Central Illinois Gastroenterology, Ltd** Permission to leave a message on your answering machine and/or voice mail. **YES** **or** **NO**
(This would be the phone number recorded in the chart unless another one is specified)

Permission to discuss your health care issues with your spouse or other designated person. **YES** **or** **NO**

**If yes, please list additional designated individuals:

	Relationship to patient	Phone Number
________________________	______________	______________
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