

Consent for the Use or Disclosure of Protected Health Information

**Colon and Rectal Associates
1811 E. Bert Kouns, Suite 430
Shreveport, LA 71105**

As required by the Health Insurance Portability and Accountability Act of 1996, Colon and Rectal Associates may use your personal health information for the purposes of treatment, payment or health care operations. The specific uses and disclosures that we intend to make are described in our Notice of Privacy Practices. You have the right to review the Notice of Privacy Practices prior to signing this consent form. You may request restrictions on the uses and disclosures described in the Notice of Privacy Practices by describing the requested restrictions in the "restriction request" section of this form. You may revoke this consent at any time by signing and dating the revocation section on your copy of the form and returning it to this office. If you refuse to sign this consent, Colon and Rectal Associates is under no obligation to treat you as a patient.

CONSENT SECTION

I, _____ (print name) hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment and health care operations. My signature below indicates that I have received, reviewed, and understood Colon and Rectal Associates Notice of Privacy Practices and have been given the opportunity to have any questions answered before signing.

I understand that I may request restrictions on the uses and disclosures of my health information at any time by completing and signing the restriction request section of this form. I further understand that Colon and Rectal Associates is not required to accept my restriction request.

I understand that I may revoke this consent at any time by signing the revocation section of my copy of this form and returning it to Colon and Rectal Associates. I further understand that any such a revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this consent.

Signature / Date

RESTRICTION REQUEST SECTION

You have a right to request restrictions on the uses and disclosures of your protected health information as described in the Notice of Privacy Practices. Colon and Rectal Associates is not obligated to accept your proposed restrictions, but will give them fair consideration. Please describe any restriction requests that you would like to make in the section provided below:

I, _____ (print name) hereby request the following restrictions on the use and disclosure of my personal health information for the purposes of treatment, payment and health care operations. This is a complete list of my restriction requests. All previously signed expressions of my wishes concerning the use and disclosure of my personal health information for the purposes of treatment, payment or health care operations are null and void.

Signature / Date

REVOCATION SECTION

I hereby revoke this consent.

Signature / Date