East Side Endoscopy, LLC

Patient Consent and Acknowledgement of Privacy Practices For Use and/or Disclosure of Protected Health Information to Carry Out Treatment, Payment and Healthcare Operations

<Patient name>, hereby states that by signing this Consent, I agree and acknowledge the following:

1. The facility's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a description of the uses and/or disclosures of my protected health information ("PHI") necessary for the facility to provide treatment to me, and also necessary for the facility to obtain payment for the treatment and to carry out its normal operations. I understand that the Privacy Notice will be available to me in the future at my request. The facility has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent. The facility reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
2. I understand that East Side Endoscopy, LLC is affiliated with the Mount Sinai Hospital System which includes (Mount Sinai Hospital, Mount Sinai Beth Israel, Mount Sinai West and Roosevelt Hospital) and that my health records will be shared with the Mount Sinai Health Information Exchange.
3. I understand that, and consent to, the following appointment reminders that will be used by the facility:
    a) A postcard mailed to me at the address provided by me; and/or
    b) Telephoning my home and leaving a message on my answering machine or with the individual answering the phone.
4. The facility may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the facility to treat me and obtain payment for that treatment, and as necessary for the facility to conduct its specific health care operations.
5. I understand that I have a right to request that the facility restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the facility is not required to agree to any restrictions that I have requested. If the facility agrees to a requested restriction, then the restriction is binding on them.
6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all *future* transactions, with the understanding that any such revocation shall not apply to the extent that the facility has already taken action in reliance on this consent. I understand that if I revoke this consent at any time, the Facility has the right to refuse to treat me.
7. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Facility will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

Patient_Sig:_____ Date:_____

Witness_Sig:_____ Date:_____

Patient Label Here