East Side Endoscopy, LLC

## Consent to the Use and Disclosure of Health Information for Treatment, Payment, and Healthcare Operations

East Side Endoscopy ("Surgery Center") and York Anesthesia, PLLC (YORK) have developed a joint notice of their privacy practices and are using this joint consent form in order to simplify the administration process for patients. The Physicians of the Anesthesia Group provide anesthesia services at East Side Endoscopy. The Surgery Center and the Anesthesia Group are separate entities and are each separately required to comply with state and federal law. They must comply with this notice and consent form. The Surgery Center and the Anesthesia Group are not responsible for the others failure to comply with the notice or consent form. By signing the consent form, you agree to this information for the purposes described below. You also acknowledge that you have received the notice that describes the privacy practices of both the Surgery Center and the Anesthesia Group.

**I understand that as part of my health care, the Surgery Center and Anesthesia Group create and maintain health records describing my health history. I understand that the Surgery Center and Anesthesia Group may use this information as:**

1. **A basis for planning my care and treatment.**
2. **A means of communication among many health professionals who contribute to my care:**
3. **A means by which third-party payers can verify that services billed were actually provided:**
4. **A tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals.**

**I hereby consent to the Surgery Center and Anesthesia Group's use and disclosure of my individually identifiable health information for the purposes listed above and other purposes relating to my treatment, the payment of my healthcare, and other health care operations of the Surgery Center and Anesthesia Group. In addition, I acknowledge that I received on the date indicated below a copy of the Surgery Center and Anesthesia Group's Notice of Privacy Practices, which describes the obligations of the Surgery Center and Anesthesia Group regarding their use and disclosure of my individually identifiable health information and my rights regarding this information. I also understand that the Surgery Center and Anesthesia Group reserve the right to change their Notice and Practices. If the Surgery Center and Anesthesia Group changes the notice, I can obtain a revised copy by asking the Administrator of the Surgery Center. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or other healthcare operations. Also that the Surgery Center and Anesthesia Group are not required to agree to the restrictions requested. However, if the Surgery Center and Anesthesia Group agree to the request, they must comply with the request of restrictions.**

**I request the following restrictions to the use or disclosure of my health information.**

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

<Patient sig>:_____ Date:_____

Patient Label Here

<Witness sig>:_____ Date:_____