Digestive Disease & Endoscopy Center, LLC

3261 Mt Vintage Way NW Suite 221, Silverdale, WA 98383 Phone: (360) 479-1952 Fax: (360) 479-0318

Patient Name: _____ Date of Birth: _____

We keep a record of your health care services we provide you. You may ask to see and copy that record. You may ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting Medical records for our practice and asking for the Privacy Officer.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed and how your information can be accessed. You may ask the front desk for a copy to read and take home. There are copies in the waiting areas for reading also and on the walls.

Please list the individuals you wish to participate in your care. If you wish limited access information to be shared please check mark restricted.

_____ ☐ Limited Access

Name of Individual Phone Number

_____ ☐ Limited Access

Name of Individual Phone Number

I agree to permit DDEC to request and obtain previous medical records from or forward records to other providers if deemed necessary to provide me with proper care and treatment.

I agree to be contacted regarding treatment options and health-related benefits regarding medical options that may improve my quality of life.

I agree to the release of all my insurance and medical information to other health care providers, my insurance company. Medicare or any third payer to facilitate health care, processing of claims and audit of payments. I understand that the information released may need to include records regarding HIV/ AIDS, sexually transmitted diseases, mental health and drug and alcohol abuse treatment information.

I will be financially responsible for any balances not covered by my insurance.

I request that payment of authorized Medicare and /or other insurance benefits be made on my behalf to Digestive Disease & Endoscopy Center.

CONSENT TO PARTICIPATE IN HEALTH INFORMATION EXCHANGE

Dr. Yee, Dr. Siddaiah, Dr. Adike, Dr. Parker, Dr. Gulati and Dr. Doherty have agreed to participate in St. Michael Medical Center's Health information Exchange (HIE). An HIE provides the technology necessary for your health care provider to share important elements of your care with other healthcare providers to carry out routine treatment, payment, and healthcare operations.

This means that if you were hospitalized at St. Michael Medical Center, important healthcare information about you, such as allergies and current medications, will be immediately available to the medical staff treating you. In addition, notes about your care while hospitalized, as well as any laboratory, imaging or other testing will be immediately available to your healthcare provider. Ultimately this leads to better, safer, more efficient care for you and your family.

By my signature below I hereby acknowledge that I have been made aware of the availability of the Notice of Privacy Practices, Consent to participate in Health Information Exchange, and Patient Consent.

_____ _____

Printed Patient Name Printed Guardian or POA Name

_____ _____

Patient Signature or Guardian/POA Signature Date

_____ _____

Printed Staff Name Staff Signature

I agree (if applicable) to give permission to have the following persons bring my minor child into the practice for medical treatment. We will not see any child without supervision by authorized adult.

Name of Individual Phone number Parent Signature