



Notice of Privacy Practices

New York Gastroenterology Associates (NYGA) provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our detailed Notice of Privacy Practices provides information about how we may use and disclose protected health information **(PHI)** you provided to New York Gastroenterology Associates **(NYGA)**. The notice contains a Patients Rights section describing your rights under the law. You have the right to review our Notice before signing this consent. The terms of our Notice may change. If we change our Notice you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how your **PHI** is used or disclosed for treatment, payment or healthcare operations. We are not required to agree to these restrictions, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of your **PHI** for treatment, payment and healthcare operations. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosure we have already made in reliance on your prior consent.

By signing below the patient understands that:

- Protected Health Information **(PHI)** may be disclosed or used for treatment, payment or healthcare operations.
- **NYGA** has a Notice of Privacy Practices and the patient has the opportunity to review the Notice.
- **NYGA** reserves the right to change the Notice of Privacy Practices policy
- The patient has the right to restrict the use of their information but **NYGA** does not have to agree to these restrictions.
- The patient may revoke this consent in writing at any time.
- **NYGA** may condition treatment upon the execution of this consent.

Signature consenting to the NYGA Privacy Practice policy:

Signature of Patient

Date

Signature of person responsible for patient

Date

Witnessed By: _____