WOODHOLME
GASTROENTEROLOGY ASSOCIATES
A LifeBridge Health Partner

HIPAA

I, (print)_____ , hereby authorize **EndoCentre of Baltimore, EndoCentre at Quarterfield Station, Woodholme Gastroenterology Associates, P.A.,** to use and/or disclose my health information which specifically identifies me or that which can reasonably be used to identify me to carry out my treatment, payment and health care operations. I understand that while this consent is voluntary, if I refuse to sign **EndoCentre of Baltimore; EndoCentre at Quarterfield Station**, **Woodholme Gastroenterology Associates, P.A.,** can decline to treat me.

I have been informed that **EndoCentre of Baltimore; EndoCentre at Quarterfield Station; Woodholme Gastroenterology Associates, P.A.,** has prepared a notice ("Notice") which more fully describes the uses and disclosures that can be made of my individually identifiable health information for treatment, payment and health care operations. I understand that I have the right to review such Notice prior to signing this consent.

I understand that I may revoke this consent at any time by notifying **EndoCentre of Baltimore; EndoCentre at Quarterfield Station**, **Woodholme Gastroenterology Associates, P.A.,** in writing, but should I do so, such revocation will not affect any actions that **EndoCentre of Baltimore, EndoCentre at Quarterfield Station, Woodholme Gastroenterology Associates, P.A.,** took before receiving my revocation.

I understand that **EndoCentre of Baltimore, EndoCentre at Quarterfield Station, Woodholme Gastroenterology Associates, P.A.,** has reserved the right to change their privacy practices and that I can obtain such changed notice upon request.

I understand that I have the right to request that **EndoCentre of Baltimore; EndoCentre at Quarterfield Station**, **Woodholme Gastroenterology Associates, P.A.,** restrict the manner in which my individually identifiable health information is used and/or disclosed to carry out treatment, payment or health operations. I understand that **EndoCentre of Baltimore; EndoCentre at Quarterfield Station, Woodholme Gastroenterology Associates, P.A.,** does not have to agree to such restrictions, but that once such restrictions are agreed to, **EndoCentre of Baltimore; EndoCentre at Quarterfield Station**, **Woodholme Gastroenterology Associates, P.A.,** must adhere to such restrictions.

_____ _____

Signature of patient or patient's representative **Date**
(Form MUST be completed before signing.)

_____

Family friend or other involved in my care

_____

Relationship to the patient