23920 Katy Freeway, Suite 560
Katy, TX 77494
281-394-0266 Phone
281-396-4340 Fax

This is a signature page only which will be scanned into your chart. By completing these sections and signing below, you acknowledge that you have read all associated forms. We created this form to make it easier for patients to complete paperwork, and to save paper.

STANDARD AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION – Persons to Whom Information May Be Disclosed

*Name:____________________________________Telephone:________________________Relationship:______________

*Name:____________________________________Telephone:________________________Relationship:______________

*Name:____________________________________Telephone:________________________Relationship:______________

Please initial below:

_______ I have read and understand the **HIPAA Notice of Privacy Practices**.

_______ I have read and understand the **Cancellation Policy** and know I will be charged a fee if I cancel or reschedule without a 24 hour notice, or no-show for my appointment or procedure.

_______ I have read and understand the **Advance Beneficiary Notice** for any future Screening Colonoscopy.

_______ I have read and understand the **Pathology Lab Service Agreement**.

_______ I have read and understand the **Former Medical Records Authorization**.

_______ I have read and understand the **Financial Responsibility**.

Print Name ____

Signature ____ Date ____________________