CRS
COLON RECTAL SPECIALISTS
NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGMENT OF RECEIPT

By signing below, I acknowledge that I have received a copy of
Colon Rectal Specialists Notice of Privacy Practices Form.

Patient Signature or Authorized Representative Signature:

Description of authorized Representative's authority to sign for the patient:

X _____ _____

Witness _____
Date: ____/____/____

DOCUMENTATION OF FAILURE TO OBTAIN SIGNED ACKNOWLEDGEMENT

On _____, 20____, Colon Rectal Specialists presented this Acknowledgment of Receipt of Notice of Privacy Practices form to _____ (the "Patient"). The Patient or Authorized Representative refused to provide a signature when requested.
Witness: _____
Date: _____/_____/_____

CONSENT FOR USE AND DISCLOSURE OF YOUR HEALTH INFORMATION

Our purpose in asking you to sign this form is to document that we have informed you that Colon Rectal Specialists may use and disclose all of your health information in our possession (referred to as "Protected Health Information"). The use and disclosure of your health information is necessary. It will be used in connection with your treatment or obtaining payment for treatment and services that we provide for you, so that we may conduct our health care operations. **For a more complete description of how our office may use or disclose your Protected Health Information, please carefully review the Notice of Privacy Practices Form that is available in the lobby waiting area.** You will see that this document contains more detailed explanations of terminology such as "treatment", "payment" and "health care operations."

You have the right to review our Notice of Privacy Practices Form prior to signing this consent. At times this form may be revised. Any such revision will be made available to you by contacting Josephine Kuhlman at 248.852.8020. Carefully review the Notice of Privacy Practices Form because it contains a list of rights that are available to you with respect to the use and disclosure of your protected health information by Colon Rectal Specialists. This includes your right to request restrictions on our use and disclosure of your protected health information. You have the right to revoke this consent at any time. If you wish to revoke this consent, you must do so in writing. By signing below, you acknowledge that you have read and understand the Colon Rectal Specialists Notice of Privacy Practices Form and that you have received a personal copy of this document.

Patient Signature or Authorized Representative Signature:

Description of authorized Representative's authority to sign for the patient:

X _____ _____

Witness _____
Date: ____/____/____