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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 and agree to all associated forms. **If you do not agree with any section below, we will be unable to move forward with your visit. Please let the front desk know if you have any questions or concerns you would like to discuss.** 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: _____
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Please **INITIAL** below:

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

_____ I have read and understand the **Informed Consent to Telemedicine Consultation**.

_____ 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 _____