



WHERE CARING IS OUR SPECIALTY

International Tower at Reston Heights
11800 Sunrise Valley Drive, Suite #250
Reston, Virginia 20191

703-429-9926
info@endoreston.com
www.endoreston.com

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice is available to you upon request.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. These changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice at any time by contacting:
Dr. Wonhee Lee
11800 Sunrise Valley Dr. Ste #250 Reston, VA 20191
Phone: 703-429-9926

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation and that we may decline to treat you or to continue treating you if you revoke this Consent.

CONSENT:

I have had a full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that by signing this Consent form, I am giving my consent to your use and disclosure of my Protected health information to carry out treatment, payment activities, and health care operations.

Patient Name: _____ Signature of Patient or Legal Guardian: _____ Date _____

The HIPAA privacy rule gives individuals the right to request restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.



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AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Authorization: By my signature below, I affirm, as a patient of the Practice named above OR as the parent or legal guardian of a minor child that is a patient of the Practice named above (the "Patient"), that I authorize the Practice: (i) to capture photographic or video images of the Patient (the "Images"); (ii) to reproduce, use, and disclose the Images, with or without the Patient's name; (iii) to publicize the fact that medical services were provided to the Patient; (iv) to reproduce and publish any testimonials the Patient provides regarding the Practice (collectively referred to herein as the "Information"); and (v) to secure copyright registration for any materials that incorporate the Information, at the election and sole expense of the Practice. The authorization is given to the Practice listed above, for disclosures to any persons, without limitation, who may view the Information in printed or digital form in promotional materials including social media or Internet sites.

Purpose: The purpose of this authorization is to permit the use of the Information, including images, for educational purposes. I explicitly consent to such use and acknowledge that no compensation will be provided for it.

Expiration and Revocability: If the Patient is signing on his or her own behalf, this authorization expires when the Patient informs the Practice that he or she is no longer a patient of the Practice. If the Patient is signing on behalf of a minor child, this authorization expires when the patient reaches the age of majority, but the authorization remains valid for protected health information already used or disclosed until revoked by the Patient who has attained majority. However, I understand that protected health information already used or disclosed prior to any revocation may no longer be protected. I understand that I may revoke this authorization at any time by notifying the Practice by Certified Mail, return receipt requested, but that revocation will only affect uses and disclosures initiated after the date notice is received by the Practice. Upon receipt of the notice of revocation, the Practice will make reasonable efforts to remove protected health information from social media platforms over which it has control but cannot guarantee removal from all sites. I understand and explicitly acknowledge that the Internet allows for wide sharing and forwarding of information and that the Practice cannot control all re-disclosure of information.

No Effect on Treatment: This authorization is voluntary. I understand that the Practice cannot condition the treatment of the Patient on whether I sign this Authorization and that my decision not to sign will not influence or affect the Patient's treatment in any way

I have read the above and fully understand the consent that I am signing.

Signature of Patient or Legal Guardian: _____ Date _____