Gastroenterology

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CONSENT to OBTAIN and/or RELEASE INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

I, _____, hereby authorize the office to use, obtain and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment, and health care operations. I authorize the office to obtain information from my pharmacy regarding my medications and/or medication history. I understand that while this consent is voluntary, if I refuse to sign this consent, the physicians may refuse to treat me.

I have been informed that the office 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 the office in writing, but if I revoke my consent, such revocation will not affect any actions that the physicians took before receiving my revocation.

I understand that the office 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 the office restricts how my individually identifiable health information is used, obtained and/or disclosed to carry out treatment, payment, or health operations. I understand that the physicians do not have to agree to such restrictions, but that once such restrictions are agreed to, the office must adhere to such restrictions.

_____ _____
Signature of patient or patient's representative Date

_____
Relationship to patient