

DIGESTIVE DISEASE CONSULTANTS, P.A.

CONSENT FOR RELEASE OF INFORMATION FOR THE TREATMENT,  
PAYMENT AND HEALTH CARE OPERATIONS

I, \_\_\_\_\_, hereby authorize Digestive Disease Consultants, P.A. to use 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 understand that while this consent is voluntary, if I refuse to sign this consent, Digestive Disease Consultants, P. A. can refuse to treat me.

I have been informed that Digestive Disease Consultants ,P.A. 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 Digestive Disease Consultants, P.A., in writing, but if I revoke my consent, such revocations will not affect any actions that Digestive Disease Consultants, P.A. took before receiving my revocation.

I understand that Digestive Disease Consultants, P.A. has reserved the right to change its privacy practice and that I can obtain such changed notice upon request.

I understand that I have the right to request that Digestive Disease Consultants, P.A. restricts how my individually identifiable health information is used and/or disclosed to carry out treatment, payment or health operations. I understand that Digestive Disease Consultants, P.A. does not have to agree to such restrictions, but that once such restrictions are agreed to, Digestive Disease Consultants, P.A. must adhere to such restrictions.

I authorize the names listed below to receive my medical information:

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

\_\_\_\_\_  
Signature of pt or patient’s representative  
(Form *MUST* be completed before signing)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of patient or patient’s representative

\_\_\_\_\_  
Relationship to patient