North Suburban Gastroenterology Associates SC

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CONSENT FOR RELEASE OF INFORMATION FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I, _____, authorize North Suburban Gastroenterology Associates SC (NSGA) 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, NSGA can refuse to treat me.

I have been informed that NSGA has prepared a Notice of Medical Privacy Practices 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 NSGA in writing, but if I revoke my consent, such revocation will not affect any actions that NSGA took before receiving my revocation.

I understand that NSGA has reserved the right to change his/her privacy practices and that I can obtain such changed notice upon request.

I understand that I have the right to request that NSGA restricts how my individually identifiable health information is used and/or disclosed to carry out treatment, payment or healthcare operations. I understand that NSGA does have to agree to such restrictions, but that once such restrictions are agreed to, NSGA must adhere to such restrictions.

_____ _____

Patient or Patient Representative Signature **Date**

_____

PRINTED Patient Name

_____ _____

Relationship to the Patient **NSGA Staff Initials/Date**

080210