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

I hereby authorize *Mid-Atlantic G.I.Consultants, P.A.* to use and/or disclose my heath information which specifically identifies me or which can reasonably be used to identify me to carry out treatment, payment, and health care operations Specifically, I authorize the release of my medical information to my insurance company or companies. I understand that while this consent is voluntary, if I refuse to sign this consent, the physicians of *Mid-Atlantic G.I.Consultants, P.A.* can refuse to treat me.

I have been informed that *Mid-Atlantic G.I. Consultants, P.A.* has prepared a "Notice of Privacy Policies" pamphlet 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 will be offered a copy of this pamphlet and will have the right to review it prior to signing this consent.

I understand that I may revoke this consent at any time by notifying *Mid-Atlantic G.I. Consultants, P.A.* IN WRITING, but if I revoke my consent, such revocation will not affect any actions that *Mid-Atlantic G.I.Consultants, P.A.* took before receiving my revocation.

I understand that *Mid-At/antic* G.I. *Consultants, P.A.* 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 *Mid-Atlantic GI. 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 *Mid-Atlantic* G.I. *Consultants, P.A.* does not have to agree to such restrictions, but that once such restrictions are agreed to, *Mid-Atlantic G.I. Consultants, P.A.* must adhere to such restrictions.

I REQUEST THAT PAYMENTS ISSUED FROM MY INSURANCE COMPANY, OR COMPANIES, BE MADE TO: *Mid-Atlantic G.I. Consultants, P.A.*

Signature of patient or patient's representative **Date**

Print name of patient or patient's representative **Relationship to patient**