Metropolitan Gastroenterology Associates, Inc.
MGA GI Diagnostic & Therapeutic Center, Inc.

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

I, _____, hereby authorize Metropolitan Gastroenterology Associates, Inc. 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, the physician can refuse to treat me.

I have been informed that Metropolitan Gastroenterology Associates, Inc. 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 Metropolitan Gastroenterology Associates, Inc., in writing, but if I revoke my consent, such revocation will not affect any actions that Metropolitan Gastroenterology Associates, Inc. took before receiving my revocation.

I understand that Metropolitan Gastroenterology Associates, Inc. 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 Metropolitan Gastroenterology Associates, Inc. restricts how my individually identifiable health information is used and/or disclosed to carry out treatment, payment or health operations. I understand that Metropolitan Gastroenterology Associates, Inc. does not have to agree to such restrictions, but that once such restrictions are agreed to, it must adhere to such restrictions.

_____ Initial here to give us permission to speak with someone in your household regarding your care or account status.
List person(s): _____

_____ Initial here to allow us to leave a message regarding your care or account status on your answering machine.

_____ _____
Signature of patient or patient's representative Date

_____ _____
Printed name of patient's representative Relationship to patient