PITTSBURGH GASTROENTEROLOGY ASSOCIATES
1350 Locust Street
Suite 406
Pittsburgh, PA 15219

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

I, ________________________________ , hereby authorize Pittsburgh Gastroenterology Associates 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, Pittsburgh Gastroenterology Associates can refuse to treat me.

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

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

____ ________________
Signature of patient or patient's representative **Date**
(Form MUST be completed before signing.)

____
Printed name of patient or patient's representative

____
Relationship to the patient