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

I, _____, hereby authorize Pittsburgh Gastroenterology Associates / South Hills Endoscopy Center 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 / South Hills Endoscopy Center can refuse to treat me.

I have been informed that Pittsburgh Gastroenterology Associates / South Hills Endoscopy Center has prepared a notice ("Privacy 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 / South Hills Endoscopy Center, in writing, but if I revoke my consent, such revocation will not affect any actions that Pittsburgh Gastroenterology Associates / South Hills Endoscopy Center took before receiving my revocation.

I understand that Pittsburgh Gastroenterology Associates / South Hills Endoscopy Center 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 / South Hills Endoscopy Center 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 / South Hills Endoscopy Center does not have to agree to such restrictions, but that once such restrictions are agreed to, Pittsburgh Gastroenterology Associates / South Hills Endoscopy Center must adhere to such restrictions.

Name of patient (or patient's representative)	Signature	Date
_____	_____	_____

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