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

I, _____, hereby authorize Northern Arizona Gastroenterology PC 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, Northern Arizona Gastroenterology PC can refuse to treat me.

I have been informed that Northern Arizona Gastroenterology PC 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 the privacy officer at Northern Arizona Gastroenterology PC, in writing. However, if I revoke my consent, such revocation will not affect any actions that Northern Arizona Gastroenterology PC took before receiving my revocation.

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

_____ _____

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

_____

Printed name of patient or patient's representative

_____

Relationship to the patient