

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

I, _____, hereby authorize Alliance Digestive Disease Consultants Medical Group, 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 have been informed that Alliance Digestive Disease Consultants Medical Group 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 Alliance Digestive Disease Medical Group, in writing, but if I revoke my consent, such revocation will not affect any actions that Alliance Digestive Disease Consultants Medical Group took before receiving my revocation.

I understand that Alliance Digestive Disease Consultants Medical Group 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 Alliance Digestive Disease Consultants Medical Group restrict how my individually identifiable health information is used and/or disclosed to carry out treatment, payment or health operations. I understand that Alliance Digestive Disease Consultants Medical Group does not have to agree to such restrictions, but that once such restrictions are agreed to, Alliance Digestive Disease Consultants Medical Group must adhere to such restrictions.

Signature of patient or patient’s representative
(Form must be completed before signing)

Date

Printed name of patient or patient’s representative

Relationship to the patient