

Palm Beach Gastroenterology Consultants, LLC

Consent For Release of Information For Treatment, Payment, and Healthcare Operations

Patient Account _____

I, _____ hereby authorize Palm Beach Gastroenterology Consultants, LLC to use and disclose my health information, which specifically identifies me or which can be reasonably be used to identify me to carry out my treatment, payment, and healthcare operation. I understand that while this consent is voluntary, if I refuse to sign this consent, Palm Beach Gastroenterology Consultants, LLC can refuse to treat me.

I have received a copy of the Notice of Privacy Standards (“HIPAA”), which more fully describes the uses and disclosures that can be made of my individually identifiable health information for treatment, payment, and healthcare operations.

I understand that I make revoke this consent at anytime by notifying Palm Beach Gastroenterology Consultants, LLC in writing, but if I revoke my consent, such revocation will not affect and action that Palm Beach Gastroenterology Consultants, LLC, took before receiving my revocation.

I understand that Palm Beach Gastroenterology Consultants, LLC has reserved the right to change their privacy practices and that I can obtain a changed notice upon request.

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

Signature of Patient/Guardian

Date _____

Printed Name of Patient

Relationship to Patient