Mid-State Gastroenterology

PATIENT CONSENT FOR RELEASE OF INFORMATION

Please Print Legibly & Complete All Information

This form is required by the federal government.

I, _____, hereby authorize **Mid-State Gastroenterology** 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, **Mid-State Gastroenterology** can refuse to treat me.

I have been informed that **Mid-State Gastroenterology** 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 have the right to obtain a paper copy upon request.

I understand that I may revoke this consent at any time by notifying **Mid-State Gastroenterology,** in writing, but if I revoke my consent, such revocation will not affect any actions that **Mid-State Gastroenterology,** took before receiving my revocation.

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

I acknowledge and agree that **Mid-State Gastroenterology** and any affiliate or vendor thereof, including collection or billing companies, may contact me by telephone or text message to any phone number I have provided to you, and any other phone number associated with my account, including wireless or mobile phone numbers. I further agree that you may use any method of contact to these numbers provided, such as an Automated Telephone Dialing System (ATDS) or prerecorded message. I also agree that I will notify **Mid-State Gastroenterology** if I have given up ownership or control of any such telephone number.

HIPAA Privacy Notice / Patient Rights / Advanced Directive

I hereby acknowledge that a copy of the Notice of Privacy Practices for **Mid-State Gastroenterology** has been made available to me. I have the right to obtain a paper copy upon request.

I have received written and verbal notification regarding my patient rights prior to my procedure. I have also received information regarding **Mid-State Gastroenterology** policies pertaining to advanced directives. Advanced Directives will not be honored within this office.

_____ _____ _____

Signature of Patient or Patient Representative *Date of Birth* *Date*

_____ _____

Print Name of Patient or Patient Representative *Relationship to Patient*

RELEASE OF MEDICAL & BILLING INFORMATION

I, _____, authorize the physicians and staff of **Mid-State Gastroenterology** to release information on file regarding my medical treatment and billing account to the person(s) listed below:

Name _____ Relationship to Patient _____

Name _____ Relationship to Patient _____

Name _____ Relationship to Patient _____

I understand that by signing this release, the designated person(s) above will be able to speak to any member of the medical staff. Furthermore, I understand that these medical practices cannot be held liable for any information the above stated person(s) may obtain regarding my medical and billing information.

_____ _____

Signature of Patient or Patient Representative *Date*

_____ _____

Signature of Witness *Date*