JAY A. CHERNER, M.D.

A Division of

GASTROENTEROLOGY CONSULTANTS, P.C.

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

I, ________________________________ , hereby authorize **Gastroenterology Consultants, P.C.** 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, the physicians of **Gastroenterology Consultants, P.C.** can refuse to treat me.

I have been informed that **Gastroenterology Consultants, P.C.** 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 **Gastroenterology Consultants, P.C.** in writing, but if I revoke my consent, such revocation will not affect any actions that **Gastroenterology Consultants, P.C.** took before receiving my revocation.

I understand that **Gastroenterology Consultants, P.C.** 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 **Gastroenterology Consultants, P.C.** restricts how my individually identifiable health information is used and/or disclosed to carry out treatment, payment or health operations. I understand that **Gastroenterology Consultants, P.C.** does not have to agree to such restrictions, but that once such restrictions are agreed to, the practice of **Gastroenterology Consultants, P.C.** must adhere to such restrictions.

I authorize **Gastroenterology Consultants, P.C.** and/or the **Georgia Endoscopy Center, L.L.C.** to leave a message regarding my appointments, treatment and results via (*please initial each response authorized*):

_____ home phone ______work phone _______ e-mail ______ cell phone

________________________________ ___________

Signature of patient or patient's representative

(Form must be completed before signing)

________________________________ _______

Printed name of patient or patient's representative

____

Relationship to the patient

Date:________________________

Please list below the names of anyone to whom we may speak and/or to whom we may release information on your behalf.

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