CONSULTATIVE GASTROENTEROLOGY

550 Peachtree Street, NE, Suite 1750, Atlanta, Georgia 30308-2263

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

I, _____, hereby authorize Consultative Gastroenterology, herein to be identified by the acronym "CG" 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 if voluntary, if I choose to withhold my signature on this consent, CG reserves the right to refuse to treat me.

I have been informed of CG's privacy policy which 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 may revoke this consent at any time by notifying CG in writing, but if I revoke my consent, such revocation will not affect any actions taken by CG prior to the receipt of my revocation. I understand the providers of CG reserve the right to alter or amend their privacy policies and that I can obtain such changed notice upon request.

I understand that I have the right to request that CG restrict how my individually identifiable health information is used and/or disclosed to carry out treatment, payment or health operations. I understand that CG is not required to agree to such restrictions, but that once such restrictions are agreed to, CG must adhere to such restrictions.

_____ Date _____

Signature of patient or representative of patient

Print Name of patient/representative

_____

Relationship to patient (if applicable)

_____

Revised 4-14-05