

MID-FLORIDA GASTROENTEROLOGY GROUP, P.A.

CONSENT FOR RELEASE OF INFORMATION, PAYMENT AND HEALTHCARE OPERATIONS

I, _____ hereby authorize, L.R. Mallaiah, M.D. 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 operations. I understand that while this consent is voluntary, if I refuse to sign this consent, L.R. Mallaiah, M.D. can refuse to treat me.

I understand (and if requested have received a copy) of the Notice of Privacy Standards (“Notice”) 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 may revoke this consent at anytime by notifying L.R. Mallaiah, M.D. in writing, but if I revoke my consent, such revocation will not affect any actions that L.R. Mallaiah, M.D. took before receiving my revocation.

I understand that L.R. Mallaiah, M.D. 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 L.R. Mallaiah, M.D. restrict how my individually identifiable health information is used and/or disclosed to carry out treatment, payment and health operations. I understand that L.R. Mallaiah, M.D. does not have to agree to such restrictions, but that once such restrictions are agreed to, L.R. Mallaiah, M.D. must adhere to such restrictions.

Signature of patient or patient’s representative Date

Printed name of patient or patient’s representative Relationship to patient

RELEASE OF CONFIDENTIAL INFORMATION

This is to inform you that, for your protection, it is our office policy not to release any information regarding your history to anyone without your permission.

If it is your desire that we be able to discuss your medical case with someone other than yourself please indicate it in the appropriate box below. Please list the names of those individuals in the space provided.

_____ I do **NOT** wish you to discuss my medical case with anyone besides myself.

_____ You have my permission to discuss my medical case with the following individual(s):

Patient’s signature Date Social Security Number