MID-FLORIDA GASTROENTEROLOGY GROUP, P.A.

L.R. MALLAIAH, M.D., F.A.C.P.
BOARD CERTIFIED GASTROENTEROLOGIST

CONSENT FOR RELEASE OF INFORMATION, PAYMENT AND HEALTHCARE OPERATIONS

I, _____hereby authorize, Lenkala 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, Lenkala 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 Lenkala R. Mallaiah, M.D. in writing, but if I revoke my consent, such revocation will not affect any actions that Lenkala R. Mallaiah, M.D. took before receiving my revocation.

I understand that Lenkala 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 Lenkala 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 Lenkala R. Mallaiah, M.D. does not have to agree to such restrictions, but that once such restrictions are agreed to, Lenkala 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 Date

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 (Please check off one of the boxes and sign below):

_____ 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):

_____ *You may also discuss my medical case and release
_____ my medical records to the following physician(s):
_____ _____
_____ _____

_____ _____ _____
Signature of patient or patient's representative Date Social Security Number