BROOKHAVEN GASTROENTEROLOGY ASSOCIATES, P.C.

Patient Information Form

Please print all information in the spaces provided. Be sure to complete and sign the statement on the bottom of this form.

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

I, _____ , hereby authorize **Brookhaven Gastroenterology Associates, 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, **Brookhaven Gastroenterology Associates, P.C.** can refuse to treat me.

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

I understand that **Brookhaven Gastroenterology Associates, 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 **Brookhaven Gastroenterology Associates, 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 **Brookhaven Gastroenterology Associates, P.C.** does not have to agree to such restrictions, but that once such restrictions are agreed to, **Brookhaven Gastroenterology Associates, P.C.** must adhere to such restrictions.

_____ _____

Signature of patient or patient's representative *Date*

(Form MUST be completed before signing.)

_____

Printed name of patient or patient's representative

_____

Relationship to the patient