THE CENTER FOR
Digestive & Liver Health
and The Endoscopy Center

Consent for Release of Information
for Medical Treatment, Payment & Health Care Operations

I, _____, hereby authorize the Center for Digestive and Liver Health or The Endoscopy Center to use, disclose and/or obtain my health information (that specifically identifies me or can reasonably be used to identify me)

- to carry out my medical treatment;
- to receive payment for services rendered on my behalf; and
- to execute general health care operations.

I understand that while this consent is voluntary, if I refuse to sign this consent, the Center for Digestive and Liver Health or The Endoscopy Center can refuse to treat me.

I have been informed by the Center for Digestive and Liver Health or The Endoscopy Center that a notice ("Notice") has been prepared to more fully describe the uses and disclosures made of my individually identifiable health information. I understand my right to review such Notice prior to signing this consent.

I understand that I may revoke this consent at any time through written notification via certified mail but if I revoke my consent, such revocation will not affect any actions taken prior to receipt of my revocation. Notification to revoke consent must be communicated via certified mail and forwarded to:

Attention –Administrator
1139 Lexington Avenue
Savannah, GA 31404

I understand that the Center for Digestive and Liver Health or The Endoscopy Center has the right to change their privacy practices and I can obtain such changed notice upon request.

I understand my right to choose to request the Center for Digestive and Liver Health or The Endoscopy Center restrict how my individually identifiable health information is used and/or disclosed to carry out my medical treatment, payment for services rendered on my behalf or to execute general health operations. I, also, understand that the Center for Digestive and Liver Health and The Endoscopy Center do not have to agree to such restrictions. However, if such restrictions are agreed to by the Center for Digestive and Liver Health and/or The Endoscopy Center, such restrictions will be adhered to.

_____ _____
Signature of Patient or Patient's Representative Date

_____ _____
Witness / Relationship Date

_____ _____
Patient's Social Security # Patient's Date of Birth

_____
Printed Name of Patient –or- Patient's Representative

THE CENTER FOR
Digestive & Liver Health
and The Endoscopy Center

Patient Contact Information

Patient Name _____

Social or MRN # _____ Date of Birth: _____

Contact Name _____

Relationship _____

Phone Number 1 _____ Phone Number 2 _____

My home answering machine does not identify me by name, but it is appropriate to leave messages for me there. (Circle) Yes No

Full Disclosure

I hereby grant permission for *Center for Digestive & Liver Health/The Endoscopy Center* to contact, disclose, and discuss my health information with the person named above. I understand that I am waiving privacy rights afforded to me under the Health Insurance Portability and Accountability Act of 1996 ("HIPPA") which became effective April 14, 2003.
This means I give permission to Center to call and/or discuss all health information including medical record information, appointments, and billing information with the contact noted above.

Patient's Signature: _____ Date: _____

Appointment ONLY

I hereby grant permission for *Center for Digestive & Liver Health/The Endoscopy Center* to contact, disclose and discuss my health information relating to appointments only: requesting, changing, and canceling with the person named above. I understand that I am waiving privacy rights afforded to me under the Health Insurance Portability and Accountability Act of 1996 ("HIPPA") which became effective April 14, 2003.
This means I give permission to Center to call and/or discuss all information regarding my appointments with the contact name listed above.

Patient's Signature: _____ Date: _____

Insurance and Billing ONLY

I hereby grant permission for *Center for Digestive & Liver Health/The Endoscopy Center* to contact, disclose and discuss my health information relating insurance and billing issues with the person named above. I understand that I am waiving privacy rights afforded to me under the Health Insurance Portability and Accountability Act of 1996 ("HIPPA") which became effective April 14, 2003. *This means* I give permission to Center to call and/or discuss all information regarding my financial obligations to the Center with the contact name listed above.

Patient's Signature: _____ Date: _____