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

I hereby authorize Bay Area Gastroenterology PA ("Office") 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, the Office can refuse to treat me.**

I have been given 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 may revoke this consent at any time by notification in writing, but if I revoke my consent, such revocation will not affect any actions that the Office took before receiving my revocation.

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

COMMUNICATIONS

I hereby authorize Office to communicate with me through: (**please check where appropriate**)

_____**Email address** _______

_____**message left at home** _____ _____ or work_____

_____**cell phone only** #_____

Please list any Family or Friends that Bay Area Gastroenterology PA may release medical/billing information to:

_____phone#_____

_____phone#_____

_____phone#_____

CONSENT FOR TREATMENT BY PHYSICIAN ASSISTANT

Office appointments with our Physician Assistant are offered to our patients. Bay Area Gastroenterology Physicians are primary supervising Physicians. The supervising physician is accessible in person, by telephone, or pager whenever needed by our Physician Assistant. There may be times that the Physician is unavoidably detained away from the office and the Physician Assistant may provide treatment to the patients until the physician arrives on site.

_____I do not wish to be seen by a Physician Assistant. (Doctor Only)

_____ _____

Patient Signature **Date**

_____

Printed name of patient