



Jerome m. Burke, M.D. William J. O’Toole, M.D. Michael J. Cassidy, M.D.
Ira A. Kelberman, M.D. Daisy Ortiz, M.D. Tracey McGinley, CRNP

**CONSENT FOR RELEASE OF INFORMATION FOR TREATMENT,
PAYMENT & HEALTH CARE OPERATIONS**

I, _____, hereby authorize Bux-Mont Gastroenterology Associates 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 Bux-Mont Gastroenterology Associates can refuse to treat me.

I have received or declined 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 health care operations.

I understand that I may revoke this consent at any time by notifying Bux-Mont Gastroenterology Associates, in writing, but if I revoke my consent, such revocation will not affect any actions that Bux-Mont Gastroenterology Associates took before receiving my revocation.

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

I also understand that if I do not put in writing a specific request, Bux-Mont Gastroenterology Associates may leave messages on my answering machine or send notices by mail to release appointment times, recalls, lab results, biopsies, billing matters and any other timely notices necessary for your total health care.

Signature of Patient or Patient’s Representative _____
Date

Print name of Patient or Patient’s Representative

Relationship to the Patient