Digestive Disease Associates Of Rockland, PC
974 Rte 45 • Pomona, NY 10970
845-354-3700 • 845-354-5439 (fax)

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

I,_____, hereby authorize Digestive Disease Associates of Rockland 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, Digestive Disease Associates can refuse to treat me.

I have had the opportunity to review 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 am entitled to a copy of such "Notice" at my request.

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

I understand that Digestive Disease Associates has reserved the right to change their privacy practices and that I can obtain such changed notice upon request.

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

_____ _____
Signature of Patient or Patient's Representative **Date**

_____
Printed name of Patient or Patient's Representative

_____
Relationship to Patient