

Long Beach Gastroenterology Associates

A MEDICAL GROUP, INC.

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

I, _____, hereby authorize Long Beach 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 treatment, payment and health care operations. I understand that while this consent is voluntary, if I refuse to sign this consent, Long Beach Gastroenterology Associates can refuse to treat me.

I have received a copy of the Notice of Privacy Practices ("Notice") which more fully describes the uses and disclosures that can be made of my individually identifiable health information for treatment, payment and healthcare operations.

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

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

Signature of patient or patient's representative

Date

Printed name of patient or patient's representative

Relationship to patient

Patient name (if not above)