CONSENT FOR TREATMENT AND RELEASE OF INFORMATION

I AUTHORIZE Middlesex Gastroenterology Associates (AKA Middlesex GI) to perform medical treatment.

I CONSENT to Middlesex Gastroenterology Associates use and disclosure of all individually identifiable personal, health, financial, and demographic information (known as Protected Health Information or PHI) for the purpose of:

- Providing medical treatment
- Obtaining payment and reimbursement
- Obtaining authorizations from my insurance for tests (where required)
- Requesting healthcare services from other providers
- Cooperating with all other providers in my medical treatment
- Fulfilling requests for information when specifically authorized by me
- In addition, doing all other things directly related to providing healthcare to me

The above purposes and all other uses are known collectively as Treatment, Payment, and Other healthcare operations or TPO.

I AUTHORIZE any physician or healthcare facility to provide upon request any PHI to Middlesex Gastroenterology Associates, when needed for purposes of TPO.

I CONSENT Middlesex Gastroenterology Associates discussing any or all of my medical care including my evaluation, treatment, diagnosis even if related to psychiatric or psychosocial impairments, substance abuse, acquired immunodeficiency virus (HIV), HIV-related opportunistic infections, or pregnancy with the following person(s):

1. ____ Relationship:____________________________
2. ____ Relationship: ____________________________
3. ____ Relationship: ____________________________
4. ____ Relationship: ____________________________

I have been given the opportunity to review and agree with the terms and conditions of Middlesex Gastroenterology's Patient Information Protection Plan.

I understand my rights to restrict the use and disclosure of PHI and revoke this consent at any time in writing.

I understand that should I choose not to consent to the terms and conditions of Middlesex Gastroenterology Associates Patient Information Protection Plan, the practice has the right to and will withhold treatment except where required by law.

Patient Name: ____

Patient Signature: ____ Date: _________________________

Insured/Guardian's Signature: ________________________________ Date: _________________________

The Health Insurance Portability and Accountability Act of 1996 prohibits the use and disclosure of protective health information for treatment, payment, and other healthcare operations without signed consent and prohibits the use and disclosure of protective health information for non-healthcare related activities without specific and explicit authorization.