ANNE THAI MD
GASTROENTEROLOGY

CONSENT FOR RELEASE OF INFORMATION FOR TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS

I _____, hereby authorize Anne Thai M.D. 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 healthcare operations. I understand that while this consent is voluntary, if I refuse to sign this consent, Anne Thai M.D. can refuse to treat me.

I have been informed that Anne Thai M.D. has prepared 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 healthcare operations. I understand that I have a right to review such Notice prior to signing this consent.

I understand that I may revoke this consent at any time by notifying Anne Thai M.D. in writing. If I revoke my consent, such revocation will not affect any actions that Anne Thai M.D. took before receiving my revocation.

I understand that Anne Thai M.D. has reserved the right to change her privacy practices and that I can obtain such changed notice upon request.

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

_____ _____

Signature of patient or patient representative Date

_____

Printed name of patient or patient representative

_____

Relationship to the patient