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Gastroenterology and Internal Medicine Specialists, S.C.

Consent to the Use and Disclosure of Medical Information for Treatment, Payment and Healthcare Operations

Receipt Acknowledgement of Notice of Privacy Practices

I consent to the use and disclosure of my medical information by **Gastroenterology and Internal Medicine Specialists, S.C.** for the purpose of diagnosing or providing treatment to me, obtaining payment for my treatment or to conduct healthcare operations of the practice. I understand that treatment by the practice may be denied if I do not sign this consent.

I understand that I have the right to request restrictions as to how this information is used or disclosed for treatment, payment or healthcare operations. **Gastroenterology & Internal Medicine Specialists, S.C.** is not required to agree to the restrictions that I may request, but if the practice agrees to a restriction, the practice is bound by the agreement.

I have the right to revoke this consent, in writing, except where the practice has already made disclosures in reliance on prior consent.

I understand and have been provided with **Gastroenterology & Internal Medicine Specialists, S.C.** Notice of Privacy Practices that provides information about how the practice may use and disclose medical information. I understand that I have the right to review the notice prior to signing this consent.

Gastroenterology & Internal Medicine Specialists, S.C. has the right to change the privacy practices that is described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling or visiting the office and requesting a revised copy.

Signature of Patient or Authorized Representative

Date

Name of Patient or Authorized Representative