



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

I, \_\_\_\_\_, hereby authorize **EndoCentre** to use and/or disclose my health information which specifically identifies me or that 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, **EndoCentre** can decline to treat me.

I have been informed that **EndoCentre** has prepared a Notice of Privacy Practices 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 have the right to review the Notice of Privacy Practices prior to signing this consent, and that I may keep the copy of it if I choose.

I understand that I may revoke this consent at any time by notifying **EndoCentre** in writing, but should I do so, such revocation will not affect any actions that **EndoCentre** took before receiving my revocation.

I understand that **EndoCentre** 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 **EndoCentre** restrict the manner in which my individually identifiable health information is used and/or disclosed to carry out treatment, payment or health operations. I understand that **EndoCentre** does not have to agree to such restrictions, but that once such restrictions are agreed to, **EndoCentre** must adhere to such restrictions.

\_\_\_\_\_  
**Signature of patient or patient's representative**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Printed name of patient or patient's representative**

\_\_\_\_\_  
**Relationship to the patient**