



Consent for Purposes of Treatment, Payment, and Health Care Operations

I consent to the use of disclosure of my protected health information by Dr. Stern, Dr. Gantt, Dr. Mullen, and Shira Spilman, PA-C for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Associates In Gastroenterology. I understand that diagnosis or treatment of me by Dr. Stern, Dr. Gantt, Dr. Mullen, and Shira Spilman, PA-C may be continued upon my consent as evidenced by my signature on this document. I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. Associates in Gastroenterology is not required to agree to the restrictions that I may request. However, if Associates in Gastroenterology agrees to a restriction that I request, the restriction is binding with Dr. Stern, Dr. Gantt, Dr. Mullen, and Shira Spilman.

I have the right to revoke this consent, in writing, at any time, except to the extent that Dr. Stern, Dr. Gantt, Dr. Mullen, Shira Spilman, PA-C, or Associates In Gastroenterology has taken action in reliance on this consent. My “protected health information” means health information, including my demographic information collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me , or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review the Associates In Gastroenterology Notice of Privacy Practices prior to signing this document. Dr. Stern, Dr. Gantt, Dr. Mullen, and Shira Spilman, PA-C's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the type of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in performance of health care operations of Associates In Gastroenterology. The notice of Privacy Practices is also provided at 9420 Key West Avenue, Suite 202, Rockville, Maryland 20850. Associates In Gastroenterology reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by mail or asking for one at the time of my next appointment.

Signature of Patient or Guardian :

Printed Name:

Description of Personal Representative's Authority:
