Capital Gastroenterology Consultants

Consent for Release of Medical Records

I hereby acknowledge that I have received a copy of Capital Gastroenterology Consultants' Privacy Notice, and that I understand my rights as listed in the Notice. I understand that my signature below gives CGC permission to use my medical record for the purpose of:

1. Providing treatment to me
2. Arranging for payment for my care
3. Capital Gastroenterology Consultants' health care operations such internal quality assessment activities.

I understand that my permission allows CGC to transmit permissible information through any means that is reasonably secure, including E-Mail, assuming that reasonable protective measures are taken to preserve the confidentiality of the information. I may revoke this authorization in writing at any time, but the Provider may refuse to give me further treatment if I do so.

Disclosure to Family/Friends

_____ I do not want The Capital Gastroenterology Consultants ("Provider") to disclose any information concerning my care or treatment by Provider to individuals without my express written consent or legal authorization.

_____ I authorize Provider to disclose information related to my care and treatment to the following named individual (s):

Name	Relationship

The authorization provided for above are subject to the following limitations or restrictions.

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Patient Name (Printed)

____ ________________

Signature of Patient (or legally responsible individual) **Date**

____ ________________

Witness **Date**