Consent for Release and Use of Confidential Information and Receipt of Privacy Practices Form

I,____hereby give my consent to **Illinois Gastroenterology Group, LLC** to use or disclose, for the purpose of carrying out treatment, payment or health care administration, all information contained in the patient record of:

Patient's Name: ____ Date of Birth___________________

I understand that employees of Illinois Gastroenterology Group will keep communications regarding my health information confidential.

Please adhere to the following communication preferences:

1. Phone: You can contact me by phone at the current phones numbers on file.
   - Leave confidential messages on answering machine. ______Yes ______No
   - Leave confidential messages with any other person. ______Yes ______No
   - You can speak to a family member or representative who calls on my behalf ______Yes _____No

If yes to leaving a message or speaking with another person, please name who we can leave a message with or receive a call from:

Name:_______________________________Phone #____________________Relationship to Patient:_________________

Name:_______________________________Phone #____________________Relationship to Patient__________________

2. __________ Mail: Contact me at the current address on file
3. __________ E-Mail: Contact me at the current email address on file.
4. __________ Other requests for confidential communication:

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I acknowledge receipt of the physician's Notice of Privacy Practices. The Notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential information. I understand that the physician has reserved the right to change his or her privacy practices that are described in the notice. I also understand that a copy of any revised notice will be provided to me or made available to me in a reasonable period of time in writing. I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so to the physician. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. Written revocation must be sent to the physician's office.

Signature____ Date____________________________