Form D

ESSEX GASTROENTEROLOGY ASSOCIATES, LLC
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CONSENT FOR USE AND DISCLOSURE FORM

(For Treatment, Payment and Health Operations)

I_____ understand that in the course of providing care to me the
(print name)
Practice will receive, create, maintain and disclose information about me for the purpose of the Practice's and other health provider's provision of treatment, securing payment from me, an insurer, other third-party payer or responsible party, and/or in connection with the health care operations of the Practice and/or the operations other health providers who have treated me and as otherwise required or permitted by State and/or Federal Law. I understand that a further description of these anticipated uses and disclosures of my health information appears in the Practice's Notice of Privacy Practices.

I agree to the sharing, utilization, examination and disclosure of any of my health information, including but not limited to known or suspected HIV/AIDS infection, mental health records, communicable diseases, substance abuse and/or treatment, if applicable, as is reasonably necessary by the Practice, its employees and other members of its workforce for the limited purpose of rendering treatment, securing payment for treatment rendered and conducting the Practice's operations. I further agree to the disclosure by the Practice of such information, as is reasonably necessary, to other health providers involved in my treatment and their employees and other members of their workforce for treatment, payment and health operations, to any private or governmental insurer, including Medicaid and Medicare and its intermediaries and agents, other third-party payers, or other financially responsible party for the purpose of determining benefits and securing payment, and as otherwise permitted by State and/or Federal law.

This consent may be revoked at any time but, only to the extent that the Practice has not acted in reliance on it. If not previously revoked, this consent will remain valid as long as I am a patient of the Practice and for such period of time thereafter as is reasonably necessary to serve the purpose for which it was given; namely, the provision of treatment, securing payment for services rendered and conducting health operations.

_____	_____
Date	Signature of patient or legal representative (if signed by a representative, print title (e.g., parent/guardian, power of attorney)