KOOROSH KOOROS,MD

PEDIATRIC GASTROENTEROLOGY

CONSENT

I consent to this practice/clinic to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations such as quality reviews.

I have been informed that I may review the Practice/Clinic Privacy Notice (for a fuller description of uses and discussions) before signing this consent.

I understand that this practice/clinic has the right to change its privacy practices and that I may obtain any revised notices in the practice/clinic.

I understand that I have the right to request restriction of how my protected health information is used. However, I also understand that the practice/clinic is not required to accept the request. If the practice/clinic agrees with my requested restriction, they must follow restriction(s).

I also understand that I may revoke this consent at any time, by making a written request, except for information already used or disclosed.

MY RIGHTS

- I understand that this authorization is voluntary, treatment, payment enrollment or eligibility for benefits cannot be a condition of signing this authorization, except if the authorization IS FOR: benefits cannot be a condition of signing this authorization, except if the authorization IS FOR:

1. Get information regarding eligibility or enrollment in a health plan.
2. Determine the obligation of an entity with respect to a claim or,
3. Create health information to provide to a third party.

- I may revoke this authorization at any time, provided that I do so in writing and present it. The revocation will take effect when Koorosh Kooros, MD/Digestive Health and Nutrition, Inc., has already trusted him.
- I am authorized to receive a copy of this authorization.

Signature: ______________________________ Date: _____________

Print Name: ________________________ Relationship to Patient: ________________

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