Gastroenterology Center of Northern Virginia, LTD.

Release of Confidential Information

I, _____ hereby give consent to Gastroenterology Center
(Name of patient or authorized agent) of Northern Virginia (GCOFNOVA) to use or disclose, for the purpose of carrying out treatment, payment, or health care operations, all information contained in the patient records.

I acknowledge the review and/or receipt of the physician's Notice of Privacy Practices. The Notice provides detailed information about how the practice may use and disclose my confidential information. I understand that GCOFNOVA has reserved the right to change its privacy practices, and that a copy of any revised Notice will be available to me upon written request.

I also authorize the physician and staff of GCOFNOVA to (please reply to all three):

1. Leave a message requesting a return call at the following daytime number:

   (_____) _____ (this is my __cell __ home __work number)

2. Leave a detailed message with the type of test(s) performed, test results and/or any other comments related to my health at:

   (_____) _____ (this is my __cell __home __work number)

3. Release any and all information pertaining to my health care, test results, procedures, billing and/or accounting information to the following person(s) or agencies:

   Name: _____ Relationship: _____

   Name: _____ Relationship: _____

   Name: _____ Relationship: _____

I understand that this consent will be actively enforced and that if I wish to change the status of this form, I must do so in person and in writing.

Patient Signature: _____ **Date:** _____

Print Patient Name: _____ **Date of birth:** _____

If not the patient, please specify relationship to the patient: _____