USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

*The educational pamphlet entitled **"Notice of Privacy Practices"** provides information about how Pediatric Gastroenterology Specialists of Maryland may use and disclose protected health information about you, and is compliant with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPPA).
*Our **Notice of Privacy Practices** states that we reserve the right to change the terms described. Should this happen, you will receive a revised copy either by mail, or in person.
*You have the right to request restrictions on how your protected health information may be used or disclosed for treatment, payment, or health care operations. We are required to agree to your restrictions, but if we do, we are bound by our agreement with you.
*By signing below, you acknowledge receipt of our **Notice of Privacy Practices**.*

RELEASE OF MEDICAL INFORMATION FOR COORDINATION OF CARE

I, hereby authorize Pediatric Gastroenterology Specialists of Maryland to release medical information to my referring physician, primary care doctor, case manager and any other individual involved in my medical care for the sole purpose of facilitating my treatment. I understand that my medical information is confidential and that I have a choice to request that my physician not share my medical records with any of the above individuals. Should I choose to exercise this right, I will provide in writing to my physician any of the individuals involved in my care whom I do not wish to receive my medical records. I agree that a copy of this release may be used in place of the original. I am aware that I may request this Release of Medical Information may be revoked at any time by providing the physician's office with a dated and signed letter. I have read and agree to those terms.

MISSED APPOINTMENT POLICY

Please be aware that by scheduling an initial consultation with our physicians, you are agreeing to abide by the billing policies of our service. To better serve all of our patients, we require a 24 hour notification should you need to cancel or reschedule your appointment. Should you miss, or reschedule your appointment with less than a 24 hour notice, you will be charged $75, and payment will be due at the time of your next appointment. Your insurance company does not cover fees for missed appointments.

AUTHORIZATION TO DISCUSS INFORMATION WITH DESIGNATED PERSON

It is often difficult to reach a patient to discuss appointments, medications and other information pertinent to our patients' care. In this event with your signed authorization we would discuss such information to a person you designate. Please complete the section below:
I hereby authorize Pediatric Gastroenterology Specialists of Maryland to discuss any information required in the course of my examination or treatment (when I cannot be reached by phone) to the following designated person(s)

Name of Designee: ________________________________ Phone Number: ________________
Relationship to Patient: ________________________________

Name of Designee: ________________________________ Phone Number: ________________
Relationship to Patient: ________________________________

- NONE

I agree to all of the above

____ __________________________

Patient or Legal Guardian Signature **Date**

____

Print Name

This form shall expire one year from the date of signature