North Idaho Endoscopy Center
Consent for Release of Information for Treatment, Payment and Healthcare Operations

I_____, hereby authorize North Idaho Endoscopy Center PLLC to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment and health care operations. I understand that while this consent is voluntary, if I refuse to sign this consent, the North Idaho Endoscopy Center can refuse to treat me.

I have been informed that the North Idaho Endoscopy Center has prepared a notice ("Notice") which more fully describes the use, and disclosures that can be made of my individually identifiable health information for treatment, payment and health care operations. This information is available at the reception desk in the waiting area and I understand that I have the right to review such Notice prior to signing this consent.

I understand that I may revoke this consent at any time by notifying the North Idaho Endoscopy Center, in writing, but if I revoke my consent, such revocation will not affect any actions that the North Idaho Endoscopy Center took before receiving my revocation.

I understand that the North Idaho Endoscopy Center has reserved the right to change his/her privacy practices and that I can obtain such changed notice upon request.

I understand that I have the right to request that the North Idaho Endoscopy Center restricts how my individually identifiable health information is used and/or disclosed to carry out treatments payment or health operations. I understand that the North Idaho Endoscopy Center does not have to agree to such restrictions, but that once such restrictions are agreed to, the North Idaho Endoscopy Center must adhere to such restrictions.

I request that payment of authorized **Medicare** benefits be made either to me or on my behalf to the North Idaho Endoscopy Center PLLC for any services furnished to me by this organization. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid, Formerly the Health Care Financing Administration and its agents any information needed to determine these benefits, or the benefits payable for related services.

_____ _____
Signature of Medicare/Medicaid Patient of Patient's Representative Date

I hereby authorize payment of medical benefits that are billed to my insurance, to be paid directly to the **North Idaho Endoscopy Center PLLC**. I hereby accept responsibility for payment for any service(s) provided to me that is not covered by my insurance. I agree to pay all co-payments, co-insurance, if the North Idaho Endoscopy Center does not participate with my insurance. If these benefits are not assigned to the North Idaho Endoscopy Center, I agree to forward all health insurance and other third party payments immediately upon receipt, for services rendered, to the North Idaho Endoscopy Center.

_____ _____
Signature of Non-Medicare/Medicaid Patient or Patient's Representative Date

_____ _____
HIPAA privacy signature Relationship to Patient

_____
Witness

North Idaho Endoscopy Center, PLLC
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