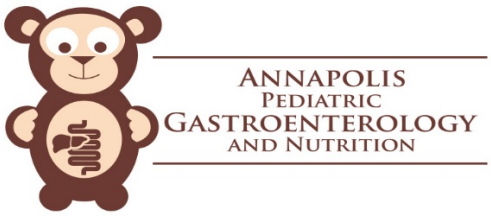

130 Lubrano Drive
Annapolis MD 21401
Phone 443-837-7600
Fax 443-837-7688

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

HIPAA Okay to Speak With

I hereby give my consent for Annapolis Pediatric Gastroenterology and Nutrition to use the disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO) Annapolis Pediatric Gastroenterology Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Annapolis Pediatric Gastroenterology and Nutrition reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request.

With the consent, Annapolis Pediatric Gastroenterology and Nutrition may call my home or other alternative location or email and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out, such as appointment reminder, insurance items and any calls pertaining to the clinical care, including laboratory results among others.

With this consent, Annapolis Pediatric Gastroenterology and Nutrition may mail to my home or other alternative location any item that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With this consent Annapolis Gastroenterology and Nutrition may e-mail to my home or other alternative location any item that assist the practice in carrying out TPO, such as appointment reminders and patient statement.

By signing this form, I consenting to Annapolis Pediatric Gastroenterology and Nutrition use the disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Annapolis Pediatric Gastroenterology and Nutrition may decline to provide treatment to me.

Signature of Patient or Legal Guardian

_____

Printed Name of Patient or Legal Guardian
_____

DATE

_____

Name of Child

_____

Name of Child

_____

Witness **_____**
_____