GASTROENTEROLOGY CONSULTANTS OF NORTH JERSEY PC
GARY GORODOKIN, M.D.

24-07 A BROADWAY
FAIR LAWN, NJ
TEL: 201-791-7760

2829 OCEAN PARKWAY
BROOKLYN, NY
TEL: 718-743-8668

CONSENT FOR RELEASE OF INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

I,_____, hereby authorize **Gary I. Gorodokin, M.D.** 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, Gary I. Gorodokin, M.D. can refuse to treat me.

I have been informed that **Gary I. Gorodokin, M.D.** has prepared a notice ("Notice") which more fully describes the uses and disclosures that can be made of my individually identifiable health information for treatment, payment and health care operations. 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 Gary I. Gorodokin, M.D. in writing, but if I revoke my consent, such revocation will not affect any actions that **Gary I. Gorodokin, M.D** took before receiving my revocation.

I understand that **Gary I. Gorodokin, M.D.** has reserved the right to change his privacies and that I can obtain such changed notice upon request.

I understand that I have the right to request that **Gary I. Gorodokin, M.D.** restricts how my individually identifiable information is used and/or disclosed to carry out treatment, payment or health operations. I understand that Gary I. Gorodokin, M.D. does not have to agree to such restrictions, but that once such restrictions are agreed to, **Gary I. Gorodokin, M.D.** must adhere to such restrictions.

_____ _____

Signature of Patient or Patient's representative **Date**
(*Form MUST be completed before signing*)

_____
Printed name of the patient or patient's representative

Relationship to the patient_____