JOHN *G.* STAGIAS, M.D.
GASTROENTEROLOGY

428 Hamilton St.
Southbridge, Ma 01550
Tel: 508-765-1600
Fax: 508-765-0253

In case of emergency contact:

Name & Relationship_____

Phone number _____

Name & Relationship_____

Phone number _____

I authorize the office staff of Dr. John Stagias to leave detailed appointment reminders.

Circle one: YES NO

If yes, please list the preferred phone number:_____

I authorize the office staff of Dr. John Stagias to leave detailed test results.

Circle one: YES NO

Preferred phone number if different than above:_____

I authorize the office staff of Dr. John Stagias to leave appointment reminders AND test results with persons other than myself if I am not available.

Circle one: YES NO

Signature Date:

JOHN G. STAGIAS, M.D.

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Southbridge, MA 01550
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*Fax: 508-765-0253*

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

**L**_____**.**

hereby authorize John G. Stagias, MD, 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, John G. Stagias, MD can refuse to treat me.

I can obtain a copy of the Notice of Privacy Standards ("Notice") upon request 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 may revoke this consent at any time by notifying John G. Stagias, MD, in writing, but if I revoke my consent, such revocation will not affect any actions that JohnJG; Stagias, MD took before receiving my revocation.

I understand that John G. Stagias, MD has reserved the right to change his privacy practices and: that I can obtain such changed notice upon request

I understand that I have the right to request that John G. Stagias, MD restricts how my individually identifiable health information is used and/or disclosed to carry out treatment, payment or health operations. I understand John G. Stagias, MD does not have to agree to sujch restrictions, but that once such restrictions are agreed to, John G. Stagias, MD must adhere to such restrictions.

Signature of patient or patient's representative Date

Printed name of patient or patient's representative

Relationship to patient