Colon Rectal Health Center

STEVEN ABBADESSA, DO

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CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS

I have been provided with a Notice of Privacy Practices, effective September 23, 2013, that provides a more complete description of my health information uses and disclosures. This notice replaces the previous notice of 2003. I understand that I have the right to review the notice prior to signing this consent. I understand that I have the right to request treatment, payment or healthcare operations.

I request the following restrictions and/or additional permissions of the use of my health information. (e.g. family members we have your permission to speak with regarding your care):

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_____

_____

_____

This authorization with remain valid unless changed by me in writing to **St. Louis Colon Rectal Health Center**.

_____ _____

Patient name (print) Date

_____

Patient signature

_____

Witness signature