



# Jose M. Ortega, MD, FACS, PA

*Diplomat American Board of Surgery • Fellow of American College of Surgeons*

Laparoscopic & General Surgery

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

I, \_\_\_\_\_, hereby authorize Jose M. Ortega, M.D., FACS, PA 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, Jose M. Ortega, M.D., FACS, PA can refuse to treat me.

I have been informed that Jose M. Ortega, M.D., FACS, PA 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 Jose M. Ortega, M.D., FACS, PA, in writing, but if I revoke my consent, such revocation will not affect any actions that Jose M. Ortega, M.D., FACS, PA took before receiving my revocation.

I understand that Jose M. Ortega, M.D., FACS, PA has reserved the right to change his privacy practices and that I can obtain such changed notice upon written request.

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

\_\_\_\_\_  
**Signature of patient or patient's representative**  
(Form must be completed before being treated)

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Printed name of patient or patient's representative**

\_\_\_\_\_  
**Relationship to patient**