

**Iberia Gastroenterology Associates, Inc.**

**W. Perry Stokes, Jr., M.D.**

2309 East Main Street, Suite 101

New Iberia, LA 70560

Phone: (337) 364-3301

**Consent for Treatment**

The undersigned, as patient or authorized agent of the patient, hereby authorizes and consents to any and all medical and diagnostic treatments as may be deemed advisable by Dr. Stokes. Being fully aware of the contents of this consent form, the patient voluntarily and knowingly gives their consent for this treatment.

**Release of Information**

Iberia Gastroenterology Associates, Inc. may obtain from any source and examine, discuss, and disclose the patient's medical record, including medical history, examinations, diagnoses, and treatments to treating doctors, Iberia Gastroenterology Associates, Inc. personnel and agents, other healthcare providers involved in the patient's care, medical researchers, audit committees, care evaluators, and state and federal agencies for the purposes of treatment, payment, or healthcare operations. For further details about these uses and disclosures see the organization's Notice of Privacy Practices. Iberia Gastroenterology Associates, Inc. reserves the right to change our privacy policies described in the Notice of Privacy Practices. You may obtain a current notice on our website, [www.drpstokes.com](http://www.drpstokes.com), or ask the receptionist, or contact us by mail.

In addition, the patient hereby authorizes Iberia Gastroenterology Associates, Inc. to release any and all medical records, including diagnosis related to alcohol and drug abuse and/or mental disorders, and billing information to the Social Security Administration, Medicare, Medicaid (or their various intermediaries), the patient's insurance company, health maintenance organization, workers compensation carrier, employer, persons acting on behalf of a preferred provider arrangement (or any of their agents or representatives), or any other individual, entity, agency or organization obligated to pay any medical expense for and on behalf of the patient **when such information is requested for payment or coverage determination purposes**. The patient understands that their medical information may be mailed, faxed, or electronically transmitted, and that the faxing or electronic transmittal may increase the risk of unintentional disclosure of such information to third parties. The patient agrees to voluntarily assume such risk in consideration of the benefits of enhanced treatment and payment resulting therefrom, and expressly authorizes such transmission releasing Iberia Gastroenterology Associates, Inc. from any liability resulting from such transmission. The patient understands that he may revoke this consent at any time by a request in writing. If he/she does revoke the consent, Iberia Gastroenterology Associates, Inc. can refuse to treat him/her. While this consent may be revoked, it cannot be retroactive to the release of information made in good faith.

Upon receiving any inquiry as to the presence or general condition of the patient, Iberia Gastroenterology Associates, Inc. may (unless otherwise requested by the patient, next of kin, or doctor) release at its discretion, the patient's name, address, age, and sex, general nature of inquiries, or the general condition of the patient.

This authorization shall remain in effect for a period of not more than one year from the date shown below or until payment of this account is rendered in full, whichever is longer. The patient hereby consents to such release of information and releases and relieves Iberia Gastroenterology Associates, Inc. from any and all legal liability that may arise from the release of this information.

**Privacy Notice**

The patient acknowledges that he/she has received a copy of Iberia Gastroenterology Associates, Inc.'s Notice of Privacy Practices (effective date: April 1, 2003) which more fully describes the uses and disclosures that can be made of his/her individually identifiable health information for treatment, payment, or healthcare operations.

*The patient has read and understands all of the above and also acknowledges receipt of the Notice of Privacy Practices.*

\_\_\_\_\_  
Patient's Legal Name

\_\_\_\_\_  
Patient/Responsible Party Signature

\_\_\_\_\_  
Date