DISCLOSURE AUTHORIZATION

Patient Name: _____ DOB:_____

Email Address: _____

Please list the family members, close friends, or other people who we can notify regarding your care or with who we can discuss your protected health information. **Protected health information consists of test results, diagnoses, billing information, insurance information and treatment options.** This form will be effective until you provide further notice to us.

Emergency Contact:

(If patient is a minor, this must be a parent or guardian)

Name: _____ Relationship to patient: _____

Primary Phone: _____ Home Cell Work (circle one) Secondary Phone: _____ Home Cell Work (circle one)

Others:

Name: _____ Relationship to patient: _____

Primary Phone: _____ Home Cell Work (circle one) Secondary Phone: _____ Home Cell Work (circle one)

Name: _____ Relationship to patient: _____

Primary Phone: _____ Home Cell Work (circle one) Secondary Phone: _____ Home Cell Work (circle one)

Name: _____ Relationship to patient: _____

Primary Phone: _____ Home Cell Work (circle one) Secondary Phone: _____ Home Cell Work (circle one)

☐ I give permission for GI Associates to leave detailed voicemail messages at this phone number _____, including but not limited to normal test results and scheduling information. Initials_____.

Patient Signature

I acknowledge my protected health information can be released to the people I have listed above. I have the right to revoke this form at any time in writing at the office listed above.

Patient / Authorized Representative Signature: _____

Date: _____

Please retain this form in the patient's medical record.

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