GASTROENTEROLOGY ASSOCIATES, P.A.

CONSENT TO COMMUNICATE WITH YOU

Option 1 ☐ I authorize Gastroenterology Associates, PA to leave results or protected health information on my voicemail.

OR

Option 2 ☐ I authorize Gastroenterology Associates, PA to **only** leave a voicemail to return a call to your practice. *(no detailed health information).*

AUTHORIZATION TO COMMUNICATE WITH OTHERS

Option 1 ☐ _____ (initial) I **do not** authorize GA to communicate with anyone other than me.

OR

Option 2 ☐ I authorize Gastroenterology Associates, PA to discuss my protected health information (information in my medical record, diagnosis or treatment plans) and payment for my care with the individuals listed below. These individuals may also consent or authorize the disclosure of my protected health information.

				Medical	Billing
Name _____	Relationship _____	Phone _____		☐	☐
Name _____	Relationship _____	Phone _____		☐	☐
Name _____	Relationship _____	Phone _____		☐	☐

I understand that I have the right to revoke this authorization, in writing, at any time, and that I have the right to inspect or copy the protected health information to be disclosed as described in the document by sending a written notification to Gastroenterology Associates, PA. I understand that a revocation is not effective in cases where the information has already been disclosed. I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned upon signing.

This information is released at the patient's request and this authorization will remain in effect until revoked by the patient.

X _____

Signature of Patient/Authorized Representative (If patient is under the age of 18, legal guardian must sign.)

PATIENT PRIVACY NOTICE ACKNOWLEDGEMENT

Gastroenterology Associates, PA has provided their Notice of Privacy Practices and I understand how my privacy is protected.

X _____

Signature of Patient/Authorized Representative

STATEMENT OF FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF INSURANCE BENEFITS

I understand that I am financially responsible for all charges not paid by insurance. I authorize the release of information to my insurance company for insurance/medical purposes. I hereby authorize payment from my insurance company to Gastroenterology Associates, PA.

X _____ _____

Signature of Patient/Authorized Representative — Patient's Date of Birth

_____ _____

Print Name — Today's Date

Revised 3-26-21

OFFICE USE ONLY

If the above patient does not sign this form, please provide a reason why the acknowledgement was not obtained and witness.

Reason(s) _____

Witness / Staff Signature _____ Date _____